RECOVERY MANAGEMENT

# Recovery Management and Peer Support

*William L. White — Selected Papers, Volume III*

69 Papers

White's research and frameworks on recovery management, recovery capital, peer support services, and recovery-oriented systems of care.

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# Selected Papers of William L. White

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

**Citation**: The Behavioral Health Recovery Management Project Project summary and concept Posted at **www.williamwhitepapers.com**


## The Behavioral Health Recovery Management Project
## Project Summary and Concept
## June 28, 2000[1]


**Michael G. Boyle, William L. White, David Loveland, Mark D. Godley, & Russell J. Hagen**


### Facing the Challenge of Severe Behavioral Health Disorders: The Behavioral Health Recovery Management Project

Chronic conditions of mental illness, alcoholism, and drug addiction often resemble the course and pattern of chronic physical disorders, such as diabetes, coronary heart disease or arthritis. Such disorders are often characterized by alternating episodes of stabilization and symptom activation that require long-term strategies of disease management. Despite recognition of this fact in the behavioral health field, treatment approaches continue to follow an acute care model as reflected in our language of "admitting" and "discharging" to and from clients' episodes of care within treatment agencies. By comparison, a primary care physician treating a diabetic patient would not discharge the patient after stabilization of a diabetic coma.

Although there is a growing recognition in primary health care for the application of disease management procedures in the treatment of chronic physical disorders, behavioral health treatment of chronic conditions of mental illness and addiction continue to be influenced by an acute medical model paradigm that has been exemplified by short-term community hospitalizations for mental illness and the 28-Day inpatient addiction rehabilitation facilities for substance abuse disorders (Hasenfeld, 1985; Price & Smith, 1983; Institute of Medicine,1990). Nearly 54% ($42.7 of $79.3 billion) of national expenditures for behavioral health in 1996 in the United States was for either short-term inpatient treatment, residential treatment, medical treatment (physician other than psychiatrist), or nursing home care (Mark, McKusick, King, Harwood, & Genuardi, 1998). Complicating the development of effective models of care in the behavioral health field is the ascent of managed care. Some

[1] The Behavioral Health Recovery Management project is a joint venture of Fayette Companies, Peoria, IL and Chestnut Health Systems, Bloomington, IL. Sponsored by: The Illinois Department of Human Services Office of Alcoholism and Substance Abuse

providers and researchers are concerned that state level managed care models will place more emphasis on cost reduction and acute intervention strategies that are influenced primarily by the bottom line rather than on treatment efficacy (Goldman & Morrissey, 1997; Mechanic, Schlesinger, & McAlpine, 1995; Newman & Tejeda, 1996; Schlesinger & Gray, 1999). The growth of behavioral health managed care with an emphasis on cost reduction over treatment efficacy may lead to the elimination of progressive, community-based models of care that are considered costly in the short term.

Concurrent with the pervasive application of managed care and the perpetuation of the acute care model, there is a growing number of individuals with multiple treatment needs (e.g. comorbid conditions of mental illness and a substance abuse disorder) (Drake, Mercer-McFadden, Muesser, McHugo, & Bond, 1998; Regier et al. 1990), that cannot be met in the current fragmented and segregated treatment system (Minkoff, 1987). Individuals with comorbid conditions, such as mental illness and an addiction, find themselves facing an increasingly complex and categorically segregated service system in which no agency has the capacity to meet their complex and often long-term needs (Krauss, 1989; Morrissey, 1999; NASADAD; 1998; Ridgely, Goldman, & Willenbring, 1990). The result of this fragmented treatment system is a perpetual pattern of exclusions, extrusions ("administrative discharges"), revolving admissions and discharges, inappropriate and potentially harmful treatment interventions such as unneeded institutionalization (e.g. incarceration) and "dumping" of individuals with complex treatment needs (Drake, Mueser, Clark, & Wallach, 1996; Ridgely, Goldman, Willenbring, 1990; Torrey, Erdman, Wolfe, & Flynn, 1990).

Finally, there is a well-documented gap between the known effectiveness of treatment approaches and the application of these practices in applied settings. While research has shown treatment for mental health and chemical dependency to be as effective as treatments for other chronic disorders, such as forms of heart disease, diabetes and some mental illness (Leshner, 1999), there is a wide breach between research and practice (Fichtner, Luchins, Malan, & Hanrahan, 1999; Francis, Docherty, & Kahn, 1996; Norquist, Lebowitz, & Hyman, 1999). There are also wide variations in treatment practices among similar populations with similar needs (Gilbert et al. 1998). In addition, many factors (e.g., funding constraints) prevent the dissemination and widespread application of numerous innovative programs in both mental health and substance abuse treatment (Torrey, 1990). The gap between clinical research and clinical practice has become a growing concern at the national level (Institute of Medicine, 1990; Institute of Medicine, 1998).

A possible solution to these compounding issues is a reconceptualization of the current behavioral health system in terms of integration across disciplines and the adoption of a service model that transcends the limitations of the traditional acute medical model (Krauss, 1989; Lebowitz & Harris, 2000; Minkoff, 1989; Norquist, Lebowitz, & Hyman, 1999; Osher, 1996). Additionally, the rise of the consumer/survivor movement in the United States is consistent with a shift from the deficit-focused professionally-driven medical model toward a strength-based approach. The latter supports the tenants of recovery over maintenance and self-determination over institutional dependency (Anthony, 1993; Chamberlin, 1990; Kaufmann, 1999).

The need to re-conceptualize the behavioral health service delivery model has provided the impetus for the development of the Behavioral Health Recovery Management Project (BHRMP), a multidisciplinary project established through the Illinois Department of Human Service's Office of Alcoholism and Substance Abuse to develop comprehensive disease management guidelines for the treatment of chronic conditions of mental illness and substance abuse disorders. The purpose of BHRMP is to develop evidence-based practice guidelines for behavioral health,

apply research to investigate the validity, cost, and utility of these guidelines, and disseminate these models with references for additional resources and training for implementation.

The guiding principles of the BHRMP are that:

- Individuals can engage in a process of recovery from chronic conditions of mental illness and drug and alcohol addictions.
- Treatment services should be ongoing and matched in type, duration, and intensity to the needs of individuals.
- Treatment is guided by a strength-based paradigm of service delivery (Rapp, 1998; Saleebey, 1997).
- Primary health, mental health, and substance abuse treatment should be integrated within providers and systems (Osher, 1996).
- A biopsychosocial approach to treatment interventions (Engel, 1977; Smith & Nicassio, 1995).
- Treatment is guided by evidence-based protocols (Rush, Rago, & Crimson, 1999; Vega, 1999).
- The community is an oasis of natural resources such as self-help/mutual-help organizations, religious organizations, housing supports, consumer-driven services, and social networks (Kisthardt, 1997) that should be incorporated into the treatment protocol (McKnight,1995).

Pharmaceutical companies and a few progressive staff model HMOs have pioneered disease mangement in general healthcare to address chronic illness. This approach frequently utilizes case management to coordinate the efforts of multi-disciplinary providers and employs evidence-based practice guidelines. A key component of a disease management program is the involvement of the client, his or her family and significant others as partners in the management of the illness. Educational programs, skills training and various audio/visual supports are used to empower the consumer to manage their condition. Empowerment of the consumer and the crucial theme of recovery in both the substance abuse and mental health fields have led this project to utilize the term “recovery management” rather than disease management. Recovery management is the mobilization and integration of personal, family, professional and indigenous community resources toward the goal of enhancing the duration and quality of life of those experiencing severe and persistent behavioral health disorders.

Recovery management offers promise for improving outcomes in the treatment of chronic behavioral health conditions and long-term cost effectiveness. The BHRM project will establish the basis of treating serious mental illness and chemical dependency as chronic diseases, establish principles in developing a recovery management approach, identify the best clinical guidelines that are evidence-based and/or consensus derived, test the guidelines in community settings, modify as necessary, and convert the guidelines to clinical algorithms where practical. Particular emphasis will be placed on identifying or developing longitudinal systems to assist individuals to manage their recovery from both substance abuse and mental illness. New approaches that will guide behavioral health organizations in service delivery are also anticipated. A web site will be used to communicate progress and issues to the field.

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## Adolescent Substance Use Disorders: From Acute Adolescent Substance Use Disorders: From Acute Treatment to Recovery Management

**William L. White, M.A., Michael L. Dennis, Ph.D., and Mark D. Godley, Ph.D.**

### Abstract

*A surge in adolescent alcohol and illicit drug use during the 1990s triggered renewed calls for evidence-based intervention programs and sparked an unprecedented federal investment in treatment-related adolescent research. This article discusses some of the major findings of this research (particularly the just-completed Cannabis Youth Treatment study) with particular reference to their implications for the design of community-based services for substance-involved youth and families. For adolescent substance use disorders characterized by high severity and chronicity, co-morbidity, and low family and social network support, the authors call for supplementing traditional, acute models of brief intervention with more time-sustained, ecologically-focused models of recovery management.*

### I. Historical Perspective

Concerns about youthful alcohol misuse arose early (1780-1820) in the American Republic during a period of heightened per capita alcohol consumption (Rorabaugh, 1979). Alarm about such misuse, particularly among orphaned children, led to minimum drinking age laws and mandatory temperance education in American schools (Mosher, 1980). Youth between 15-20 constituted nearly ten percent of admissions to nineteenth century inebriate homes and inebriate asylums (White, 1998). The opening decades of the twentieth century witnessed growing concerns about non-medical opiate and cocaine use among youth. This was followed by cultural attention to rising alcohol and cannabis use in the 1930s and considerable alarm about resurging juvenile narcotic addiction in the 1950s. While youth addicted to opiates were included within the few available treatment institutions of the 1950s,

adolescents entering treatment were generally viewed as miniature versions of adult addicts (Conferences, 1953).

Mid-century recognition of the need for specialized treatment for adolescent substance use disorders led to the opening of the first specialized adolescent treatment facilities, the birth of youth-focused addiction ministries, and the rise of young people's meetings within Alcoholics Anonymous and Narcotics Anonymous. The most noted of the juvenile facilities (Riverside Hospital in New York City) closed when it was discovered that most youth relapsed following their discharge from treatment (Gamso and Mason, 1958). Rising polydrug experimentation of the 1960s and 1970s triggered an increase in the number of youth seeking admission to treatment. While there were a few youth-oriented outpatient treatments and minor adaptations of residential treatment models, services to most substance-involved adolescents were provided in adult treatment units. The failure of these programs to provide developmentally appropriate services contributed to poor treatment outcomes and a call for specialized adolescent treatment models (Sells and Simpson, 1979; Craddock, Bray, and Hubbard, 1985; Dennis, et al., in press).

The new generation of adolescent treatment programs of the 1980s and 1990s were marked by youth-oriented assessment and treatment protocol, a greater focus on family involvement in treatment, the inclusion of academic/vocational remediation within the treatment milieu and the recognition of the needs of special populations of youth, e.g., runaways, minority youth, and youth experiencing co-occurring disorders (Catalano et al, 1991; Muck et al., 2001; Williams & Chang, 2000)

The expansion of community-based treatment for substance-involved youth was accompanied by calls for evidence-based treatment practices. Three federal agencies--The National Institute on Alcohol Abuse and Alcoholism (NIAAA), The National Institute on Drug Abuse (NIDA), and The Center for Substance Abuse Treatment (CSAT)—responded by funding adolescent treatment research and by widely disseminating the findings and implications of such research studies to the design and delivery of treatment and support services for substance-impacted youth and their families. The speed of this area of knowledge development is quite remarkable. Thirty-two of 53 adolescent treatment outcome studies reviewed by Williams, et al. (2000) were published after 1990, and it has been estimated that the number of such studies will double in the next five years (White, Dennis and Tims, 2002).

This article will highlight what we believe to be six of the most important lessons emerging from the latest adolescent treatment research. In discussing these lessons, we will acknowledge the availability of brief, low cost interventions that are effective in treating many adolescent substance use disorders, and explore the role community helpers can play in supporting the long-term recovery of youth who present with substance use disorders of high severity and chronicity.

We will use data from one of the most recent of these studies—CSAT's Cannabis Youth Treatment (CYT) study—to illustrate these lessons (Dennis, Titus et al., in press). The CYT study randomly assigned 600 adolescents meeting diagnostic criteria for cannabis abuse or dependence within four treatment sites to one of five types of outpatient treatment. Seventy-one percent of admitted youth completed the treatment to which they were assigned, and 94% were interviewed quarterly for the first year following enrollment (all CYT interventions were complete at 3 months and follow-up continued for 3 additional quarters). The adolescents treated had an average age of 16 and were predominately male (83%), white (61%), in school (87%), and involved in the juvenile justice system (62%). (The treatment manuals used within the CYT study may be obtained by contacting the National Clearinghouse on Alcohol and Drug Information, 1-800-729-6686 or www.health.org; a bibliography of the overall CYT findings is posted at www.chestnut.org/li/cyt.)

## II. Recent Research Findings/Implications

Lesson 1. *The risk and severity of substance-related problems are magnified by lowered age of onset of regular use.* The risk of substance abuse/dependence is not uniform across substance using youth. Those who begin drug use before age 15 are six times more likely than those who begin drug use after age 18 to develop adult symptoms of drug dependence. Nearly 85% of the CYT adolescents started using between the ages of 12 and 14. There is a growing body of evidence that early onset of drug use is associated with increased risk of adult substance use disorders, increased severity of those disorders, poorer treatment outcomes and longer addiction careers (the length of time between first use to achievement of stable recovery) (Chou and Pickering, 1992; Grant and Dawson, 1997). This lowered age of drug experimentation reflects the rise in the number of children who are approaching and entering adolescence in family/social environments characterized by high drug availability and norms that tolerate or promote drug experimentation. Reduced age of drug exposure may become recognized as one of the most clinically and socially significant drug trends of the twentieth century. The growing recognition of substance use in early adolescence has spurred the redesign of prevention efforts since the late 1970s (Evans, et al., 1978). Accumulating data about the social and clinical significance of the progressive lowering of age of onset of drug use is spurring more focused and sustained prevention and early intervention strategies, particularly among high-risk youth. Postponing, if not preventing, exposure to intoxicants to the latest point in the transition from childhood to young adulthood is a crucial strategy in the goal of reducing alcohol- and other drug-related problems.

Lesson 2*: Substance use disorders of adolescence rarely present in isolation from other problems (Grella, et al., 2001; Hser, et al., 2001).* Of the adolescents admitted to treatment within the CYT study, 95% reported one or more other problems (83% had three or more). The most frequent psychiatric problems included major depression, generalized anxiety, suicidal thoughts or actions, traumatic stress disorders (60% reported a history of victimization), conduct disorder, and attention deficit-hyperactivity disorder. Other commonly reported problems included family instability, school failure, enmeshment in deviant peer cultures, and criminality. Two findings are consistent within the recent research literature: 1) youth with pre-existing problems are at higher risk for substance use disorders, and 2) substance use plays a role in the onset and exacerbation of other problems. These findings reinforce the need for broad-spectrum biopsychosocial (as opposed to problem-specific) screening and assessment procedures, and the need for multi-disciplinary, multi-agency intervention models that can provide an integrated response to multiple, co-occurring problems of youth and families.

Lesson 3: *Adolescent substance use disorders present in both acute and chronic patterns*. The former are more likely to respond to brief, outpatient or residential therapies as evidenced by sustained abstinence (or only minor relapses) and significant improvement in functioning following treatment. The five brief interventions tested in the CYT study were all associated with major reductions in substance use, symptoms of dependence or abuse, behavioral problems, family problems, school problems, and illegal activity. At 12 months, nearly a third of those youth completing CYT treatment were living in the community without any marijuana use or substance related problems. This reflects the good news of adolescent treatment outcome research: there are brief treatments that can have positive and enduring effects on the lives of many young people and their families.

The more ominous news within recent adolescent treatment outcome studies is documentation of the presence of many youth for whom substance use has already

become a chronic condition and way of life. In the CYT study, 41% of the adolescents had failed earlier attempts to quit on their own, a quarter reported earlier admission to treatment, and a third were re-admitted to treatment in the year following their discharge from the CYT study. While such findings may stir therapeutic pessimism about the treatment of adolescent substance use disorders, we believe these findings instead confirm the need for different types and levels of care within the rubric of adolescent treatment.

Lesson 4*: Most treated adolescents will vacillate between periods of recovery and periods of drug use and drug-related problems in the year following their first treatment episode.* The portrayal of adolescent substance use treatment as a brief clinical encounter that either works (complete and enduring abstinence following treatment) or does not work (any drug use following treatment) is inconsistent with the actual phenomenon of adolescent addiction and recovery. After CYT treatment, we found that 60% had some period of recovery: 29% went into recovery but later relapsed; 7% went into recovery, relapsed, but then resumed recovery; 15% did not respond to treatment right away but did get better during the subsequent months; and 9% recovered right away and stayed in recovery through the first year following treatment. These findings suggest that most adolescents are precariously balanced between recovery and reactivation of substance use in the months (and particularly the first 90 days) following completion of treatment. Most disturbing is the fact that addiction professionals are typically not present in the lives of treated adolescents and their families when the shifts to stable recovery or reactivation of substance use occurs in the weeks and months following acute intervention (Godley, et al., in press).

Lesson 5*: Post-treatment monitoring and recovery support services offer promise in enhancing adolescent treatment outcomes (Stout, et al., 1999; Godley, et al, in press)*. The fragile and fluid nature of the post-treatment recovery experience invites a new service model that shifts from the "diagnose, admit, treat, discharge" approach of the hospital emergency room to a sustained model of recovery management that more closely resembles the model of disease management used to treat diabetes, hypertension and asthma (McLellan, et al., 2000; White, Boyle, and Loveland, in press). These latter approaches focus on problem stabilization, recovery education, ongoing monitoring, professionally hosted support networks, and, when needed, early re-intervention (White and Dennis, 2002).

Lesson 6: *Greater attention must be given to the ecology of recovery from adolescent substance use disorders*. The advancements in the treatment of substance use disorders point toward the family, the peer culture, the school and the larger community as important mediators in post-treatment recovery or relapse. It is becoming increasingly clear that the substance-impacted adolescent cannot be treated without treating the environment in which he or she resides. What is needed is nothing short of building indigenous cultures of recovery that can nurture adolescents during and following their experiences in professionally-directed treatment. This requires constructing and utilizing recovery support systems within the world the adolescent inhabits: within the family, the school, the neighborhood, and the wider community. For those adolescents most deeply involved in substance use, the goal is to move them from a drug-saturated culture of addiction to a youth-oriented culture of recovery (White, 1996).

## III. The Future

In an earlier review (White, Dennis and Tims, 2002) we predicted the rapid development and wide dissemination of evidence-based, manual-guided approaches in the treatment of adolescent substance use disorders (also see Stevens and Morral, in press). We also predicted that mainstream treatment agencies would come to incorporate many of the key elements of treatment research infrastructure (standardized biopsychosocial assessment

protocol, evidence-based treatment manuals, competency-based training of clinicians, model fidelity instruments /procedures, and rigorous clinical supervision). Based on this current review, we also envision a shift in the locus of treatment for those adolescents presenting patterns of high problem severity and complexity. This shift will be from sequential, self-encapsulated episodes of acute, institutional care to a more time-sustained, community support model of recovery management. We envision increased partnerships between addiction treatment agencies, youth and family service agencies, newly created community supports (e.g., recovery schools) and indigenous support structures (youth-focused mutual aid societies) to create recovery sanctuaries for drug-impacted youth and their families.

The treatment of adolescent substance use disorders is rapidly evolving from clinical folklore to a science-guided endeavor, and its focus is shifting from the institutional environment to the natural environment in which sustainable recovery must be inevitably rooted and nurtured. Providers of community-based youth and family services constitute important partners in the construction of supports for the long-term recovery of substance-involved adolescents and their families.

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# Behavioral Health Recovery Management: A Statement of Principles

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Behavioral Health Recovery Management is a model of intervention for severe mental illness and severe substance use disorders that shifts the focus of care from professional-centered episodes of acute symptom stabilization toward client-directed management of long-term recovery. The following 11 principles distinguish the Behavioral Health Recovery Management (BHRM) model.

**1. Recovery Focus:** Full and partial recoveries from severe behavioral health disorders are living realities evidenced in the lives of hundreds of thousands of individuals in communities throughout the world. Where complete and sustained remission is not attainable, individuals can actively mange these conditions in ways that transcend the limitations of these disorders and allow a fulfilled and contributing life. The BHRM model emphasizes recovery processes over disease processes by affirming the hope of such full and partial recoveries and by emphasizing client strengths and resiliencies rather than client deficits. Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioral health disorders.

**2. Client empowerment:** The client, rather than the professional, is at the center of the BHRM model. The goal is the assumption of responsibility by each client for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life. Client empowerment involves not just self-direction of one's own recovery, but opportunities for involvement in the design, delivery and evaluation of services provided by behavioral health organizations and involvement in shaping public attitudes and public policies regarding behavioral health disorders.

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**3. The Destigmatization of Experience:** The BHRM model seeks to "normalize" or otherwise respect a person's experiences with behavioral health disorders and subsequent services. In this way, the person escapes attacks on self-esteem and self-efficacy that often accompany the stigma of mental illness. Moreover, the public begins to endorse positive images of behavioral health that undermine the prejudice and discrimination that frequently accompanies services.

**4. Evidence-based Interventions:** The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process. The "evidence" under girding such interventions includes scientific studies (randomized clinical trials, clinical field experiments) and inter-disciplinary professional consensus regarding promising approaches, but the ultimate evidence is the fit between the intervention and the client at a particular point in time as judged by the experience and response of the client.

**5. Development of Clinical Algorithms:** As knowledge and application of evidence based

practices advance, the challenge becomes knowing what treatment approaches to use with specific individuals as they progress through the stages of change and stages of treatment. Medication algorithms have been developed that specify preferred first line prescriptions for specific diagnoses, dosing and time frames for evaluating the effects. Similar practice support algorithms are needed for clinicians utilizing psychosocial treatments.

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**6. Application of Technology:** The rapid advances in technology must be applied to recovery from serious mental illness and addictions. Technology being utilized in other fields may be adopted or adapted to addressing behavioral health issues. While web based services and supports are currently being explored, what other technologies could be made available for treatment and recovery support? Is there an application for GPS, nanotechnology or other developing scientific advances? Many technologies could be applied today while we await the miracles that will arise from the human gnome project through fields such as genetic engineering and bioinformatics.

**7. Service Integration:** Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than territorial ownership of the person's problems. The goal is to mesh these historically isolated services into an integrated, recovery-oriented system of care. The BHRM model advocates multi-agency, multidisciplinary service models that can provide less fragmented and more holistic care.

**8. Recovery Partnership:** In the BHRM model, the traditional professional role of "expert" and "treater" progressively shifts to a recovery management partnership with the client. Within this partnership, the professional serves primarily as a "recovery consultant." The service relationship within the BHRM model is marked by continuity of contact in a primary service relationship (with a recovery consultant) over time--a relationship analogous to that between a physician and patient managing any health care problem characterized by chronicity and episodic acuity.

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**9. The Ecology of Recovery:** The family (as defined by the client) and community constitute a reservoir of support for long-term recovery from behavioral health disorders. The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioral health disorders. The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the client. One of the major goals of the BHRM model is to create the physical, psychological and social space within which recoveries can flourish in local communities.

**10. Monitoring and Support Emphasis:** The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary re-engagement and early re-intervention. This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders. It also contrasts with mental health programs that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

**11. Continual Evaluation:** Service and support interventions must be matched not only to the

unique needs of each client but to the stage-specific needs of each client as these needs evolve through the stages of recovery. In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode. There is also a shift from evaluating single episodes of care to evaluating the effect of particular combinations and sequences of interventions on the course of behavioral health disorders and on recovery careers.

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## An Addiction Recovery Glossary
## The Languages of American Communities of Recovery

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Health and social problems are usually studied by examining their sources, patterns and consequences. The rationale for this approach is that understanding such factors will lead to effective prevention and intervention strategies. While this approach has led to remarkable breakthroughs in certain areas of medicine (e.g., infectious disease), the promises of similarly striking breakthroughs in understanding and treating historically intractable problems like addiction remain unfulfilled. Since Benjamin Rush's 1784 treatise on chronic intoxication, generations of addictionologists have authored texts and articles about the pathology of addiction. Studying addictive drugs, studying why people use them, generating speculative essays on why some people can't stop using them, and describing and evaluating countless efforts to punish or treat those with alcohol and other drug problems are all part of the multi-billion dollar, problem-focused addiction industry.

There is another approach–one that focuses not on the sources of addiction, but on the successful solutions that already exist in the lives of hundreds of thousands of individuals, families and communities. These solutions are of two types: people with great access to alcohol and other drugs who do not use such substances or who use but do not develop alcohol and other drug (AOD) problems, and people who have achieved a sustained resolution of AOD problems across a wide spectrum of problem severity. This second approach assumes that the study of resiliency and recovery may hold keys to more effective strategies for preventing and managing AOD problems–strategies quite different than those flowing from the pathology perspective.

Two fledgling movements are adding momentum to this shift from a pathology paradigm to a resiliency and recovery paradigm. The first is a New Recovery Advocacy Movement that is challenging the

growing restigmatization, demedicalization and recriminalization of addiction and pushing pro-recovery social policies and recovery-focused service programs (White 2000, 2001a). By bringing recovered and recovering people and their families into the forefront of policy advocacy, this movement is shifting the policy agenda from the nature of the problem (i.e., "alcoholism is a disease") and rationales for intervention effectiveness ("treatment works") to the recognition of the existence of lived solutions (i.e., "recovery is everywhere") and the nature of those solutions ("there are many pathways to recovery").

There are also signs of a Treatment Renewal Movement whose focus is on improving the clinical technology of addiction treatment, elevating the ethical practice of addiction treatment and reconnecting addiction treatment agencies to the communities out of which they were born (White, 2002a). This movement promises to shift addiction treatment from a model of serial episodes of acute treatment (assess, admit, treat, discharge) to a model of sustained recovery management and support (White, Boyle & Loveland, 2002).

The shift from a pathology perspective to a resiliency and recovery perspective requires new ways of thinking and a new language to frame the sources and solutions to alcohol and other drug problems. In earlier essays, I traced the history of the language used to frame AOD problems (White, 2004), called for the rejection and or refinement of much of the traditional language used to depict alcohol and other drug problems and their resolution, and began to articulate a pro-recovery rhetoric (White, 2001b). This paper builds on this earlier work by cataloguing and discussing some of the emerging recovery-related terms and concepts.

What follows is a glossary of the words and ideas that are central to the recovery experience of hundreds of thousands of individuals and families. It is not intended to be a glossary of the people and institutions that make up the history of the recovery cultures that have surrounded that experience. It is focused instead on accurately and respectfully conveying the key words and ideas that have initiated and anchored recovery across the boundaries of gender and ethnicity, the sacred and the secular, and the varying goals and methods of problem resolution

There are two intended audiences for this paper. The first audience includes those in recovery who experientially know the recovery tradition of which they have been a part, but may know little, and may have many misconceptions about, the central ideas of other recovery traditions. The second audience includes those working in addiction treatment who, compared to earlier decades, are less likely to be in personal recovery or to have direct knowledge about mutual aid groups. The goal is to help treatment professionals and recovery advocates understand the many recovery styles and traditions that are flourishing in America. The goal is to help the treatment professional and recovery advocate become multilingual in their efforts to widen the doorways of entry into recovery.

The glossary contains language used within diverse communities of recovery in America and the language applied to these groups and their practices by the scholars who have studied them. Some terms have emerged from formal studies on the processes involved in addiction recovery. Where these have been drawn from published sources, I have tried to provide citation of sources, particularly where a particular concept may stir controversy. Some terms are part of the vernacular of local recovery support groups, recovery advocacy organizations, and recovery-oriented treatment programs. I have tried to summarize the most common meaning of these terms as I have encountered them in my travels across the U.S. Other terms included here are part of the emerging lexicon of the Behavioral Health Recovery Management (BHRM) project (www.bhrm.org) that I have worked within the past three years. My BHRM colleagues– Michael Boyle, David Loveland, Pat Corrigan, Russell Hagen, Mark Godley, and Tom Murphy, have helped sharpen my own

thinking about many of the terms and concepts discussed here.

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## A Recovery Glossary

**Abstinence-based Recovery** is the resolution of alcohol- and other drug-related problems through the strategy of complete and enduring cessation of the non-medical use of alcohol and other drugs. The achievement of this strategy remains the most common definition of recovery, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition (See partial recovery, moderated recovery, serial recovery).

**Acts of Self-Care** constitute one of the four daily rituals of recovery. These rituals, which involve efforts to reverse the damage of addiction and establish new health-oriented habits, can also be thought of as acts of self-repair. Care of the "self" in recovery transcends the self-centeredness that is the cumulative essence of addiction. Acts of self-care might more aptly be described as acts of responsibility–responsibility not just to self and to family and community.

**(Unpaid) Acts of Service** are activities that aid other individuals or the community. They constitute one of the four core activities within the culture of recovery. Acts of service fulfill at least two functions: they constitute generic acts of restitution for the addiction-related harm to others, and, by piercing the narcissistic encapsulization of the recovery neophyte, they open up opportunities for authentic connection with others. Acts of service come in many forms: Such acts are done for their intrinsic value and not for profit or hope of acknowledgment.

**Acultural Style (of recovery)** is a style of recovery in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery. The term acultural refers specifically to a lack of identification with a larger recovery community, e.g., involvement in a culture of recovery (White, 1996).

**Addiction Ministry** refers to the outreach, treatment and recovery support services offered through the auspices of local churches as part of their ministry to their local community. The growth in addiction ministries, particularly within African American communities, constitutes one of the most significant developments in the modern history of recovery support structures.

**Affiliated (or Assisted) Recovery** (versus solo recovery) is a style of recovery in which the initiation and maintenance of recovery is achieved through relationships with other individuals in recovery. Affiliated recovery also reflects incorporating the status of addiction and recovery into one's personal identity and story style.

**Alexithymia** is the inability to cognitively label and express one's own feelings and experiences. The term has relevance here as a metaphor for the experience of people for whom traditional words and ideas do not accurately depict their problematic alcohol/drug relationships or serve as a catalyst for change. While this condition is often attributed simply to a person's failure to "get it," the solution is usually found in an alternative set of words, metaphors and relationships that do fit their experience and needs and that do incite change. (See Metaphors of Transformation)

**(Making) Amends** are acts of restitution performed by recovering people for the wounds they inflicted on others during the pre-recovery years. Making amends--repaying the literal and symbolic debts accrued in addiction--diminishes guilt and anchors recovery upon the values of responsibility, justice and citizenship. This

process also opens up the potential for atonement and forgiveness. (See Restitution)

**Amplification Effect** is the strengthening of treatment and/or recovery support services by combining or sequencing particular interventions, activities, or experiences. These combinations and sequences interact synergistically to produce changes of greater intensity than would be achieved if the same elements were used in isolation from each other or in less effective sequences. For example, an individual in Twelve Step recovery may get greater benefit from combining active step work, meeting attendance, service work, and extra-meeting social activities than by doing any one of these activities in isolation.

**Anonymity** is the tradition within Twelve Step programs to not link one's full name to AA/NA at the level of "press, radio, and films" (and one would assume television and the Internet). This did not preclude many early prominent AA members' involvement in advocacy activities. Several AA members, including co-founder Bill Wilson, testified before congress in support of specific legislation, making certain to clarify that they were speaking as individuals in recovery and not on behalf of AA as an organization. Anonymity is a tradition limited to Twelve Step groups and is not practiced in such organizations as Secular Organization for Sobriety or Women for Sobriety. Going public with one's recovery status is viewed in some cultural contexts as an important dimension of recovery (Williams, 1992).

**Assisted Recovery** is the use of professionally-directed treatment services or participation in mutual aid groups to initiate or sustain recovery from addiction (See Solo Recovery, Natural Recovery).

**The Beast (a.k.a. Monster, Dragon, Demon, Devil)** is a mythomagical personification of addiction--the compulsion to use and the voice self-talk) that feeds that compulsion. The "Beast" is a prominent metaphor within the philosophy of Rational Recovery. Externalizing thoughts that support addiction in the persona of the Beast provides a mechanism of control over such self-talk. Rational Recovery promotes a particular technique (addiction voice recognition training–AVRT) to identify and self-manage such thoughts (Trimpey, 1989). References to "Chasing the Dragon" and "Sleeping with the Devil" as metaphors for addiction, and references to "Battling with the Demon," "Grappling with the Monster" and "Slaying the Dragon" as metaphors for addiction recovery date back more than a century (Dacus, 1877; Arthur, 1877; Parton, 1868). Such terms reflect the process through which the recovering person castigates and degrades a previously loved object in order to create distance between themselves and the poisonous object of their affection.

**Bicultural Style (of recovery)** is a style of recovery in which individuals sustain their recovery through simultaneous involvement in the culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). A bicultural style of recovery implies the possession of subcultural and cultural skills to fluidly move in and out of the activities and relationships in the recovery culture and activities and relationships with individuals in the larger society (White, 1996).

**Born Again** is a phrase used to depict the state of Christian conversion. In the context of recovery, it refers to a type of quantum change characterized by egocide (death of the old self), a new Christ-centered identity, deliverance from desire (craving) and entry into membership in a sober, faith-based community. (See Conversion and Redeemed)

**Centering Rituals** are regular, alone-time activities that help keep one recovery-focused. Praying, meditating, reading pro-recovery literature, journaling, setting daily goals and taking an end-of-day inventory, and carrying/wearing sacred objects/symbols are common centering

rituals of people in recovery. Other such rituals within the history of recovery include fasting, sweating, seclusion, aerobic exercise (running, swimming), chanting, singing, dancing, artistic expression, and pilgrimages to sacred places.

**Character Defects**, within Twelve Step recovery, are those "emotional deformities" that have hurt alcoholics and those close to them. These liabilities include pride, greed, lust, anger, gluttony, envy, and sloth (the "Seven Deadly Sins"). They include obsession ("instincts gone astray") with sex, power, money, and recognition. They include self-centeredness, self-pity, intolerance, jealousy, and resentment. The A.A. program suggests that if identified and disclosed (via the Forth and Fifth Steps), these "ghosts of yesterday" would be replaced by a "healing tranquility." (Twelve Steps and Twelve Traditions, 1981, pp. 42-62.

**Character Reconstruction** is the process of bringing one's personal character into congruence with the aspirational values imbedded within recovery frameworks, whether these be Twelve Step groups, secular support structures, religious organizations or cultural revitalization movements. Character reconstruction underscores that full recovery from severe alcohol and other drug problems entails more than the removal of alcohol and other drugs from an otherwise unchanged life. It entails instead the transformation of the whole person—creating a character and a lifestyle in which alcohol and other drugs have no place.

**Choice (versus coercion)** refers to the role of volition and human will in addiction recovery. As treatment has taken on a coercive nature in past decades, the admonition that "recovery is a choice" is a reaffirmation that treatment can be coerced but that the state of recovery is a doorway that can only be entered through one's own act of choice. It is in exercising this ultimate power of choice that one moves from the self-conscious and oft-uncomfortable state of not using to the state of being free to not use.

**Chronic Diseases** are disorders that cannot be cured with existing medical technologies and whose symptoms wax and wane over an extended period of time. These disorders often spring from multiple, interacting etiological roots; vary in their onset from sudden to gradual; and are highly variable in their course (pattern and severity) and outcome. The prolonged course of these disorders places a sustained strain on the adaptational resources of the individual and his or her family and friends. Chronic addictive disorders call for a process of sustained recovery management (See Disease Concept).

**Circles of Recovery** are places where people from many recovery traditions can come together for sharing and healing. Recovery circles, which began in Native American communities in the eighteenth century, continue in those communities today (Coyhis, 1999)

**Clinical versus Community Populations** distinguishes the recovery prospects and processes of those with AOD problems in community studies from those with AOD problems who seek mutual aid and professionally-directed treatment services. Compared to the former, the latter present with greater problem severity, greater physical and psychiatric co-morbidity, and fewer family and social supports (Dawson, 1996; Ross, et al, 1999). These differences underscore the problem in attempting to transfer recovery research findings across these two quite different populations.

**Cocoon** is a metaphor of the personal transformation process. It portrays a stage of recovery marked by the need to draw into oneself–to move into a period of isolation and metamorphosis. It is often within this metaphoric cocoon that the business of identity and character reconstruction occurs. It is informative that some of the most powerful transformation experiences in the history of recovery occurred within such

isolation. Jerry McAuley's conversion in Sing Sing Prison (White, 1998), Bill Wilson's "Hot Flash" in Charles Towns Hospital (Kurtz, 1979), the transformation of "Detroit Red" into Malcolm X in a jail cell (Malcolm X with Haley, 1964) all offer vivid testimony to the power of this cocoon phenomenon. The death-rebirth experiences of the Native Americans who led prophetic, abstinence-based cultural revitalization movements also reflect this cocoon-like process of personal transformation and recovery (Coyhis and White, 2003).

**Cognitive Reappraisal** is a conscious assessment of the pros and cons of continued alcohol and other drug use and the assessment of the pros and cons of ceasing such use. Such reappraisal is a common precursor to the initiation of recovery.

**Commitment** is a (usually public) declaration of one's recovery goal. Such declarations, whether in the nineteenth century ritual of "signing the pledge" or through one's self-introduction at a mutual aid meeting, mark a shift from the contemplation and preparation stages of change to the action stages of change (Prochaska, et al, 1992). (See Developmental Models of Recovery) Commitment can also take the form of religious pledges. Muslims with a history of excessive drinking who decide to quit drinking often do so by performing ablution (cleansing of the body) and, with their hand on the Holy Qur'an, pledging, "By Allah the Great and His Book, I will never touch kmamr (alcohol) again" (Badri, 1976).

**Complete Recovery** is a phrase used by Dr. Michael Picucci (2002) to describe an advanced state of recovery marked by global health, a heightened capacity for intimacy, serenity and self-acceptance.

**Confession** is acknowledging in the presence of another flawed human being one's transgressions, imperfections, personal failings and misdeeds. Some people believe that a Higher Power is present in such events. Confession in its various forms has been an element of nearly all frameworks of addiction recovery. Brumbaugh (1994) has pointed out an important distinction between the acknowledgement of such transgression within religious and non-religious frameworks of recovery. In the former, the person receiving the confession is "not vested with the power of absolution;" "atonement is not a function of forgiveness (by another person) but lies in the process of disclosure itself."

**Continuity of Contact** is a phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope. The phrase also refers to the reliability and endurance relationship between the recovery coach (recovery support specialist) and the individual being provided recovery management services. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships (See Recovery Support Services).

**Conversion** is the initiation of recovery through a climactic physical/emotional experience. The potential role of religious conversion in remitting alcoholism has been long noted (Rush, 1784; James, 1902). Miller and C' de Baca (2001), have recently referred to such dramatic experiences as "quantum change" and noted that this type of recovery experience was marked by high vividness (intensity), suddenness (unintentional), positiveness and permanence of effect. The history of recovery in America is replete with such powerful transformation experiences: Handsome Lake, John Gough, Dr. Henry Reynolds, Bill Wilson, to name just a few. The behavioral changes elicited in such conversion experiences touch the very core of personal identity and values (See Born Again, Cocoon, Surrender).

**Crosstalk** is the use of direct responses (feedback, suggestions) to disclosures within a mutual aid meeting. Crosstalk is contrasted with sharing, in which meetings consist of serial monologues. Recovery groups vary widely on their practices regarding sharing and crosstalk. Most Twelve Step groups discourage crosstalk. Other groups, like LifeRing Secular Recovery, allocate time for both functions with most of the time devoted to sharing. Some groups such as Moderation Management encourage crosstalk (see Sharing).

**Cultural Pathways of Recovery** are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. For example, in societies in which alcohol is a celebrated drug, particularly among men, cultural pathways of recovery constitute those socially accepted ways in which a man can abstain from alcohol and maintain his identity and manhood within that society. Across varied cultural contexts, that pathway might be medical (an alcohol-related health problem), religious (conversion and affiliation with an abstinence-based faith community), or political (rejection of alcohol as an "opiate of the people.")

**Cultural Recovery** refers to the healing of a culture whose values and folkways have become corrupted and illness-producing. Cultural healing involves a return to wellness-promoting ancestral traditions or reformulation and reapplication of ancestral traditions to contemporary life (Simonelli, 2002).

**Cultural Revitalization Movement** is a sobriety-based social movement that, while seeking to renew and revitalize a culture through the reaffirmation of lost values and ceremonies, also provides a therapeutic framework for recovery from addiction and the development of health and wholeness. Such movements most often arise within historically disempowered communities. The roots of organized recovery in America actually begin with the abstinence-based, cultural and religious revitalization movements within Native American tribes in the eighteenth century (White, 2001a; Coyhis & White, 2003)

**Culture of Recovery (Recovery Culture)** is a social network of recovering people that collectively nurtures and supports long term recovery from behavioral health disorders. This culture has its own recovery-based history, language, rituals, symbols, literature, institutions (places), and values. It helps facilitate the reconstruction of personal identity and social relationships for those extracting themselves from deep enmeshment within drug and criminal subcultures.

**Decolonization** is the process through which formerly colonized peoples seek political, economic and cultural emancipation. Decolonization can spur recovery movements via cultural revitalization movements that castigate alcohol and other drugs as tools of political and psychological colonization. In the framework of these movements, abstinence from alcohol and other drugs is an act of personal resistance and an act of cultural survival. Decolonization calls for protest and community building as an alternative to self-anesthesia and self-destruction (See Freedom, Genocide, Liberation).

**Dependency Transfer** is the substitution of a positive addiction for a negative addiction. In Alcoholics Victorious, for example, recovery is viewed as a process of transferring dependence upon alcohol and other drugs to a dependence upon Christ.

**Developmental Models of Recovery** are conceptualizations of the stages and processes involved in long term recovery from addiction. Such models assume that there are discrete stages of recovery, that certain tasks and milestones within one stage must be completed before one can progress to the next stage, and that the types of treatment and support services differ considerably across these developmental stages. Those who have

developed such models of recovery include Wallace (1974); Brown (1985); Biernacki (1986); and Prochaska, DiClimente, and Norcross (1992). What these models imply is that treatment interventions and recovery support activities that are effective at one stage of recovery may be ineffective or even harmful at another stage of recovery. Such models have gone by many names including the "cycle of sobriety" (Christopher, 1989, 1992). (See Stage One Recovery, Stage Two Recovery, Complete Recovery, Disengaged Recovery, Recovery Career)

**Disease (Concept)** is a term used to depict the nature of addiction. The "disease concept", the source of which is often misattributed to A.A. (Kurtz, In Press), is an esteem-salvaging, guilt-assuaging metaphor for many people in recovery from severe alcohol- and other drug-related problems. The concept identifies those in recovery as sick people in the process of getting well as opposed to bad people trying to be good. A.A. co-founder Bill Wilson suggested that Silkworth's conceptualization of alcoholism as an allergy "explains many things for which we cannot otherwise account" (Alcoholics Anonymous, 1976). Much the same could be said for "disease," although early A.A. leaders avoided using such a designation (Kurtz, In Press).

**Disease Management (Distinguished from Recovery Management)** is the management of severe behavioral health disorders in ways that enhance clinical outcomes and reduce social costs. Its focus is on developing technologies of symptom suppression and reducing the number, intensity and duration of needed service interventions. Recovery management, while potentially achieving these same goals, focuses not on the disease and its costs but primarily upon the person and their needs and potentials. Recovery management emphasizes a person-focused rather than disease/cost-focused service orientation.

**Disengaged (style of) Recovery** is the initiation of recovery through professionally-directed treatment, mutual aid participation or both, followed by the subsequent maintenance of that recovery without significant participation in addiction recovery mutual aid groups. Such an individual might be referred to as a recovery graduate in the sense that alcohol and drug problems and their resolution constituted a chapter in their lives which is now closed, leaving them free to move forward and write new chapters of their lives. Tessina (1991) has referred to this stage of moving beyond addiction recovery as the "real thirteenth step."

**Desist/Desistance**, in the Islamic tradition, is the rejection of Al-Khamr (all things intoxicating). When the Prophet Mohammed attacked strong drink and drunkenness as an "infamy of Satan's handiwork" and asked a crowd, "Will you then desist?" they responded, "We have desisted O Allah" (Badri, 1976, p. 3-5)

**Drift** is a sociological term that depicts how some addicted people simply "go with the flow," only to find that events and circumstances lead to a drift away from drugs and the culture in which drug use was nested (see Waldorf, 1983; Biernacki, 1986, 1990; Granfield and Cloud, 1999). This style of problem resolution is not planned or even conscious, and such resolution may occur without the individual embracing either an addiction or recovery identity. The fact that this has been noted in studies of natural recovery from opiate addiction but not in comparable studies for alcoholism or nicotine addiction suggests that drift may be less possible when one's primary drug is physically and culturally ever-present.

**Drug Substitution** has two meanings in the context of recovery. The first is the long recognition of vulnerability for drug substitution in the recovery process. The addictions literature is replete with the tales of people who shed one drug only to develop an equally destructive or more destructive relationship with one or more other drugs. The observation of this risk drawn from treatment and mutual aid populations who present with high severity and chronicity is tempered by a growing number of research

studies documenting how many individuals with alcohol or other drug problems in the general population use substitute drugs to manage craving and to phase themselves out of the addictive lifestyle. While noting the potential risk of secondary drug dependence, most of these studies report that secondary drug dissipates in most individuals after 12-18 months (Biernacki, 1986; Christo, 1998; McIntosh and McKegany, 2002).

**Drunkalogue** is an oft-repeated, presentation of one's drinking career. Such presentations are known for their rote delivery and for the grandiosity they often contain. While drunkalogues seem to serve a recovery maintenance function for some individuals, the negative aspects of the drunkalogue (wallowing in the "what we were like" phase of one's story) have led groups (e.g., LifeRing Secular Recovery) to promote "soberlogues" as an alternative: a presentation that focuses on one's current life in sobriety rather than in the past (Handbook of Secular Recovery, 1999, p. 31). It is important, however, not to underestimate the therapeutic functions (problem acceptance, identity affirmation, recommitment) that such periodic recounting serves for some individuals in recovery..
Dual Recovery (see Serial Recovery)

**The Ecology of Recovery** is a phrase intended to reinforce the idea that there are ecosystems that can nourish recovery experiments and ecosystems that can crush recovery experiments. The study of the ecology of recovery focuses on the way in which an individual's relationship with his or her physical and social environment influences the viability and quality of recovery. The phrase suggests a possible integration between clinical models that focus on the individual and public health models that focus on the drug and the context and consequences of drug-taking or drug-abstaining decisions. More radical conceptualizations of addiction and recovery see the former emerging "organically" from a sick social system and view recovery as contingent upon creating a healthier social system that makes recovery possible (see Tabor, 1970)

**Eleventh Step Groups** are organized groups that help A.A. members who share a religious commitment pursue continued work on Step Eleven: "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." Two of the oldest Eleventh Step groups are the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS). Eleventh Step groups usually serve as adjuncts rather than alternatives to A.A. participation (White, 1998).

**Emancipation/emancipated** (See Freedom from Slavery)

**Emotional Sobriety** is a phrase coined by A.A. co-founder Bill Wilson (1958) to describe a state of emotional health that far exceeded simply the achievement of not drinking. Wilson defined emotional sobriety as "real maturity...in our relations with ourselves, with our fellows and with God." See Wellbriety.

**Empowerment** is the experience of having power and control over one's own destiny. Within the recovery context, there are two quite different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), addiction-related erosion of competence is often countered by increased grandiosity and preoccupation with power and control. It should not be surprising then that transformative breakthrough of recovery is marked by a deep experience of surrender and an acceptance of powerlessness. In contrast, the culturally disempowered (those for whom value has been systematically withheld) are often attracted to psychoactive drugs in their quest for power, only to discover over time that their power has been further diminished. Under these conditions, the initiation of recovery is often marked by the assumption of power and control rather

than an abdication or surrender of such power. This point is well-illustrated by the first statement of Women for Sobriety ("I have a life-threatening problem that once had me"), and the "first act of resistance" of the Afrocentric model of recovery pioneered by Rev. Cecil Williams in San Francisco ("I will gain control over my life"). In Williams' words, "a black person hears the call to powerlessness as one more command to lie down and take it" (1992, p. 9). Similar sentiments can be found in Native adaptations of the Twelve Steps, e.g., Step Two: "We came to believe that a power greater than ourselves could help us regain control" (Coyhis, 1999). Empowerment is inspiring, horizon-raising, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problem of addiction in disempowered communities lies within those very communities. Empowerment occurs, in part, when people impacted by addiction cast aside their victimhood and become active participants in healing themselves, their families and their communities. (See Hope-based Interventions and Resistance)

**Enabling**, 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.

**Enmeshed Style (of recovery)** refers to the initiation and maintenance of recovery while almost completely sequestered within the culture of recovery. Such enmeshment serves to isolate the individual from the culture of addiction and can also, at least for a time, isolate one from the larger "civilian" culture.

**Evidence-based Practices (EBP)** are clinical and service practices that have scientific support for their efficacy (work under ideal conditions) and effectiveness (work under real conditions). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to promote those practices that have the greatest impact on the quality of life of individuals, families and communities. One reviewer offered the observation that the growing preoccupation with EBP marks a shift in focus from subjective experience to objective outcome, raising the possibility that important dimensions of recovery could be lost if healers are transformed into procedural technicians. The concern expressed here is that there may be important aspects of the recovery experience that are not measurable.

**Ex-Addict** is a term that was commonly used in the therapeutic communities of the 1960s and 1970s to refer to those individuals who had successfully recovered from addiction to drugs (usually narcotics). The term is noteworthy in its depiction of the status (identity) of addict in the past tense–something one was but no longer is–in contrast to the ritual self-introduction in NA, "My name is____ and I'm and addict." This distinction hinges on the question, "Once addicted, does one ever cease being an addict?" There are recovery frameworks that answer this question quite differently (see Recovered/Recovering, Disengaged Recovery, Styles of Recovery).

**Excessive Behavior** refers to the propensity of those recovering from severe alcohol and other drug problems to experience problems with other excessive behavior, particularly during their early recovery years. Excessive relationships with

secondary drugs, work, money, sex, food, risk (e.g., gambling), and religion are common in early recovery. Working through this propensity for excessive behavior (even excessive work on recovery) is a normal part of the recovery process, and underscores the importance of such values as harmony and balance in the transition from the early to the middle stages of recovery (White, 1996). Excessiveness may even be an ally in the early recovery process (See Preferred Defense Structure).

**Expectancy Factors** refer to one's view of the future with or without drugs—views that change dramatically in the transition from addiction to recovery. Recovery is marked by changes in addiction expectancies and recovery expectancies. Opportunities for recovery increase when the expected pleasure of drug use diminishes and the perception of the likelihood of incapacitating consequences shifts from a remote possibility to likely and imminent. Recovery opportunities also increase when recovery rewards are seen as significant and immediate (Fiorentine & Hillhouse, 2000; Burman, 1997).

**Faith-based Recovery** is the resolution of alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and within the mutual support of a faith community. Faith-based recovery frameworks may serve as adjuncts to traditional recovery support programs or serve as alternatives to such programs.

**Family** is the inner social network that surrounds the individual experiencing a severe alcohol or other drug problem. In most recovery circles, family is defined more by function than by blood.

**Family-centered Care** refers to a treatment philosophy in which the family, rather than the individual, is the primary "client." Such philosophies are usually implemented by offering family members clinical services that focus on their problems and needs.

**Family Illness** refers to the way in which all members of the family and the family unit as a whole are wounded by the addiction of one of its members.

**Family Recovery** has three dimensions: the healing of individual family members, the healing of family subsystems (adult intimacy needs, parent-child relationships, and sibling relationships), and achieving recovery-conducive boundary transactions with people and institutions outside the family. While the order in which these subsystems heal can vary, family research (Brown and Lewis, 1999) suggests that individual recovery of family members must precede the recovery of the family as a unit (see Trauma of Recovery).

**Freedom (from Slavery)** is a metaphor used to confront addiction in the lives of historically colonized or enslaved peoples (particularly African Americans) (See the liberation theology of Cone, 1984; Williams, 1992). Such framing posits the role of alcohol and drugs as a tool of the colonizer to both wound and anesthetize the colonized. This metaphor can be heard in the rhetorical teachings of many African American Leaders. James Baldwin (1962) reflected these sentiments when he declared that the streets of Harlem would be flowing with blood but for the anesthesia of booze, dope and religion. He challenged African Americans to "throw off the chains of the slavemaster" by refusing to drink his alcohol and use his dope. Slavery (to sin) as a metaphor for addiction and freedom (deliverance, liberation) as a metaphor for recovery can also be found within many religious traditions. For example, the "FREE-N-ONE" ministry in Chicago is a Christian fellowship of men and women who have "emerged victoriously" from their addiction to alcohol and/or other drugs. Their only requirement for membership is a "desire to be FREE." (FREE-N-ONE, ND)

**Genocide (as a recovery metaphor)** is traditionally defined as a planned scheme to destroy a race or otherwise defined group of people. Genocide attacks the very

foundations upon which a group of people exist–their physical safety, their family and kinship structures, their language, their cultural, economical and political institutions and their dignity and spirit. The term takes on meaning in the context of addiction recovery when alcohol and other drugs become viewed as tools of such genocide and abstinence becomes viewed as an act of resistance–an act of personal and cultural pride and survival. Such a shift in worldview, long noted as a potential dimension of recovery, involves a redefinition of self, a reconstruction of family and social relationships, a new perception of the order of the universe, and a new understanding of alcohol or other drug problems (Kennedy and Humphreys, 1994). Such shifts in worldview provide a metaphor for understanding one's addiction and recovery in a larger historical and political context. Such worldviews shifts have been particularly important in inciting or anchoring recovery among disempowered peoples. In this shift, AOD use once experienced as an act of rebellion–a refusal to be acculturated–suddenly is seen as an imposed scheme of personal and cultural suicide. In this shift, radical abstinence becomes an act of purification and a refusal to die physically, psychologically, or culturally. The link between genocide and addiction is a theme found in abstinence-based, Native American cultural revitalization movements and among some African American groups. Black Panther Michael Tabor (1970) called dope a "form of genocide in which the victim pays to be killed."

**Giving It Away** is a phrase that captures one of the many paradoxes of recovery: that the methods and fruits of recovery cannot be fully experienced and understood until they are given to someone else.

**Gratitude** is the experience of ultimate reprieve—the gift of one's own life. It is the source of such recovery values as humility and service.

**Guidelines/Limits** constitute a moderation-based technology of alcohol problem resolution. For members of Moderation Management (or those who are seeking a solo approach to moderating their drinking), guidelines provide a framework that defines the meaning of drinking ("a small, enjoyable part of life"), the frequency of drinking (not every day), the frequency of non-drinking (at least 4 days per week), what to do in combination with drinking (eating), what not to combine with drinking (driving or other potentially dangerous situations), and the quantity of drinking (not more than 3 drinks per day for women and 4 drinks per day for men). Those within MM who cannot consistently adhere to these guidelines are encouraged to develop abstinence as a personal goal (Kosok, 2001).

**Habilitation** is the process of constructing a recovery identity from new rather than old building blocks. Rather than retrieving what one lost through addiction; it is building recovery from that which one never had. (See Recovery)

Habit-breaking, in the context of recovery, is the conceptualization of alcohol and other drug problems as an acquired habit and the resolution of these problems through the application of techniques used to cease long-standing habits (Dorsman, 1991).

**Harm Reduction (as a stage of recovery)** is the term used to depict strategies aimed at reducing the personal and social costs of alcohol and other drug use. Often viewed as an alternative to and even antagonistic to recovery, harm reduction approaches can also be viewed as a strategy for protecting the individual, family and community while enhancing recovery readiness.

**Healing Forest** is a metaphor used in The Red Road to Wellbriety (2002) suggesting that healthy seeds cannot grow in diseased soil and that injured seeds need a healing forest in which they can be repaired and flourish (see Ecology of Recovery).

**High Bottom Recovery** refers to the initiation of recovery through a breakthrough of awareness of all that one could lose

through continued alcohol and other drug use. References to “high bottom alcoholics” refer to people who entered recovery without having suffered major losses due to their drinking (see Low Bottom Recovery).

**Higher Power** is, in the Twelve Step tradition, the personification of a positive power “greater than ourselves” that can restore sobriety and sanity to the addicted. Referred to as the “God as we understood Him,” Higher Power is the personified antidote to the Beast.

**Hitting Bottom** is an addiction-related experience of complete anguish and despair. Studies have long affirmed the role of this “hitting bottom” experience (heightened AOD-related consequences and threat of greater consequences) and/or (a dramatic breakthrough in self-perception) in the initiation of recovery. The experience has been characterized as an “existential crisis” (Coleman, 1978), a “naked lunch” experience (Jorquez, 1993), a “brief developmental window of opportunity” (White, 1996), a “turning point” (Ebaugh, 1988), a “crossroads” (Klingemann, 1991, 1992), and an “epistemological shift” (Shaffer and Jones, 1989).

**Hope-based (as opposed to pain-based) Interventions** are interventions into the lives of people with severe alcohol- and other drug-related problems that rely not, on enhancing a pain-based crisis, but on enhancing a hope-inspired leap into recovery. Where traditional pain-based interventions rely on amplifying the experience of alcohol- and other drug-related consequences, hope-based interventions rely on living proof (role models) of what is possible, encouraging change, expressing confidence in the individual’s ability to change, and providing concrete steps of how the recovery journey can begin. Pain-based interventions rely on threats of what we will do TO you; hope-based interventions are based on a promise of what we will do WITH you. Hope-based interventions are particularly important for historically disempowered and personally victimized people who have developed massive capacities for physical and psychological pain and who exhibit chronic, self-defeating styles of interacting with professional helpers.

**Identity Realignment** is the process of retrieving a pre-addiction identity, salvaging and fully developing an identity not spoiled by addiction, or creating a new post-addiction identity. Such realignment represents a new or refined definition of who one is (one’s identity) and what one does (one’s role) (Biernacki, 1986). The hope that a spoiled identity can be repaired or replaced is a crucial dimension of the experience of hope for recovery. The successful rehabilitation of “self” is crucial to the consolidation of recovery (McIntosh and KcKeganey, 2002). The early stages of this identity realignment are marked by self-loathing, self-examination, confession and forgiveness, identity reconstruction, restitution, purging of toxic emotions, and mastery of self-defeating behavior (White, 1996).

**Idolatry** in the context of recovery, is the framing of addiction as the sin of worshiping a false god. Such references can be found within many religious traditions. In Islam, for example, alcoholism is viewed as a fruit of the tree of Jahiliyyah (ignorance/idolatry) (Badri, 1976).

**Illness Self-management** is the mastery of knowledge about one’s own illness and assumption of primary responsibility for alleviating or managing the symptoms and limitations that result from it (Corrigan, 2002). Such self-education and self-management shifts the focal point in disease management from the expert caregiver to the person with the illness. (See Empowerment and Recovery Management)

**Indigenous Healers and Institutions** are people and organizations in the natural environment of the recovering person who offer words, ideas, rituals, relationships and resources that help initiate and/or sustain the recovery process. They are distinguished

from professional healers and institutions by training and purpose as well as by relationships that are culturally-grounded, enduring, reciprocal and non-commercialized.

**Initiating Factors ("Triggering Mechanisms")** are those factors that spark a commitment to recovery and an entry into the personal experience of recovery. Factors which serve this recovery priming function are often quite different than those factors that later serve to sustain recovery (Humphreys, et al, 1995). Recovery-initiating factors can exist within the person and within the individual's family and social environment. These factors can include pain-based experiences, e.g. despair, exhaustion and boredom with addictive lifestyle; AOD-related death of someone close; pressure to stop using; a humiliating experience; health problems. They can also include hope-based experiences: exposure to recovery role models, a new intimate relationship, marriage, parenthood, a religious experience, or a new opportunity. This synergy of pain and hope creates a sequence in relationship to recovery: The experience of pain (I need to do this); the desire to change (I want to do this); belief in the possibility of change (I can do this); commitment (I am going to do this; experiments in abstinence (I am doing this); and move from sobriety experiment to stable sobriety and recovery identity (I have achieved this; this is who I now am) (See Prochaska, et al, 1992)

**Intervention** is a process of precipitating a change-eliciting crisis in the life of a person experiencing a substance use disorder by conveying the consequences of his or her behavior on family, friends and co-workers.

**Inventory** is a process of auditing one's assets and deficits of experience and character. In Twelve Step-guided recovery, this process is linked to three other processes (confession, acts of restitution, and acts of service) that serve as mechanisms for the alleviation of guilt shame as well as for character reconstruction.

**Liberation** (See Freedom, Slavery, Decolonization) can be a powerful metaphor for recovery among historically disempowered peoples. It is in this context that the phrase "liberation by any means necessary" takes on personal as well as political meaning (Tabor, 1970).

**Low Bottom Recovery** refers to the initiation of recovery by individuals in the latest stages of addiction who have experienced great losses related to their drinking and drug use. Low bottom recovery is associated with the experience of anguish and desperation–a choice between recovery on the one hand and insanity and death on the other (see Hitting Bottom).

**Maintenance Factors** are those activities and influences that serve to stabilize, consolidate and strengthen long term recovery from alcohol and other drug problems (Humphreys, et al, 1995). Recovery maintenance factors include geographical/social disengagement from the culture of addiction; negotiation of entry into the straight world; development of a sobriety-based social support system; institutional re-connection (family, church, school, workplace, pro-social community organizations); non-drug-related leisure activity; resolution of family distress/conflict; improved relationships with parents or children; positive response from significant others, family and friends; a stable economic support system; solidification of new identity; and the use of "justifying rhetorics" (personal rationales for abstinence) (Schasre, 1967; Moos, et al, 1979; Tuchfield, 1981; Granfield and Cloud, 1999; Sobell, Ellingstad, and Sobell, 2000; McIntosh and McKeganey, 2002). Overall, recovery maintenance factors are generated through the diminishment of pain and global improvements in multiple areas of life functioning, including the enhancement of meaningful and pleasurable activities and relationships (Blomqvist, 1999; Larimer and Kilmer, 2000; Humphreys et al, 1995; Tucker

et al, 1994; King and Tucker, 1998). The number and quality of pro-recovery relationships is predictive of recovery maintenance (Margolis et al, 2000; Gordon and Zrull, 1991; Stall and Biernacki, 1986; Laudet and Savage, 2000).

**Manual-guided Recovery** depicts the growing trend toward proceduralizing the steps of addiction recovery so that such recoveries can be self-initiated and self-managed over time without the use of professionally-directed treatment services or involvement in formal mutual aid societies. (See Solo Recovery)

**Mass Abstinence** is the resolution and prevention of alcohol and drug addiction through the collective decision of a people/community/culture to reject all consumption of alcohol and other drugs (Badri, 1976). Such mass action has often been the result of broad social movements (the American temperance movement), cultural revitalization movements within disempowered communities (See Willie, 1979; Chelsea and Chelsea, 1985; Taylor, 1987; and Williams, 1992), or through religious reformation movements.

**Maturing Out** (See Natural Recovery)

**Medication-assisted Recovery** is the use of medically-monitored, pharmaceutical adjuncts to support recovery from addiction. These include detoxification agents (e.g., clonidine), stabilizing agents (e.g., methadone), aversive agents (e.g., disulfram), antagonizing agents (naloxone), and anti-craving agents (acamprosate, naltrexone). They also include medications used to lower risks of relapse via symptom suppression of one or more co-occurring physical or psychiatric disorders. The use of such medications in the context of treatment is known as pharmacotherapy. The stigma attached to medication-assisted recovery (e.g., methadone) is being countered by wider dissemination of the research supporting its scientific efficacy as well as through the growing participation in recovery advocacy activities of people who have successfully achieved medication-assisted recovery. One goal of such advocacy is to have people in medication-assisted recovery recognized as legitimate members of the recovery community.

**Medicine Wheel** is a Native American system of teaching and healing that includes the four directions, the four elements (earth, fire, air and water), the four peoples (Red, White, Black and Yellow), and the four directions of growth. Medicine wheel teachings, with their emphasis on interconnectedness and harmony, have figured prominently in Native American recovery frameworks (The Red Road to Wellbriety, 2002)

**Meeting** is the basic unit of interaction and mutual identification within the culture of recovery in America. In spite of the dramatic differences between AA, WFS, SOS, LifeRing Secular Recovery, Moderation Management, Alcoholics Victorious, and other mutual aid groups, they all share the "meeting" as the central ritual of commitment and communication. The importance of this ritual is intriguing in light of the fact that "meetings" per se are not talked about in most of the basic texts of these groups. Some recovery frameworks such as Rational Recovery (Now AVRT—Addictive Voice Recognition Training) no longer utilize meetings as a recovery support mechanism.

**Meeting Types and Formats** refers to the boundaries of inclusion and exclusion of meetings (open versus closed; gender mixed or men/woman only; young people, smoking/non-smoking) and the style and content of a mutual aid meetings, e.g., speaker meetings, discussion meetings, or study meetings (texts, steps/principles).

**Metaphors of Transformation** are personally and culturally meaningful words and ideas that serve to catalyze or crystallize recovery efforts. Such metaphors are highly variable within and between cultures and draw their power from personal/cultural fit rather than scientific validity. Words, ideas, metaphors, symbols, and rituals that incite

change in one personal (e.g., gender, age) or cultural (ethnic, class) context may provide no such catalyzing effects in other contexts. White and Chaney (1993) have described critical differences in the dominant metaphors within recovery programs evolving out of men's experience versus those that have evolved out of women's experiences. The latter programs emphasize empowerment rather than powerlessness, internal rather than external resources, divided attention rather than focused attention, shame rather than guilt, self-esteem rather than humility, and place great emphasis on physical and psychological safety and on body image.

**Mirroring Rituals** are activities that bring us into relationship with other people who share our aspirational values. In the context of recovery, they are rituals of fellowship in which recovery identities and recovery communities are solidified through the acts of storytelling and mutual support. Mirroring rituals (sharing, listening, observing, laughing) constitute one of the four core activities within the culture of recovery.

**Moderated Recovery (Moderated Resolution)** is the resolution of alcohol or other drug problems through reduction of alcohol or other drug consumption to a subclinical level (shifting the frequency, dosage, method of administration, and contexts of drug use) that no longer produces harm to the individual or society. The concept takes on added utility within the understanding that alcohol and other drug problems exist on a wide continuum of severity and widely varying patterns of acceleration and deceleration. Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting that moderation was an option for some problem drinkers but not alcoholics like themselves. The following two excerpts reflect their beliefs about the issue of moderation.

*Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason--ill health, falling in love, change of environment, or the warning of a doctor--becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention* (p. 31, first edition).

*If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people!* (p. 42, first edition)

The prospects of achieving moderated recovery diminish in the presence of lowered age of onset of AOD problems, heightened problem severity, the presence of co-occurring psychiatric illness, and low social support (Dawson, 1996; Cunningham, et al, 2000; Vaillant, 1996). The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood. Most of these individuals do not go on to develop enduring AOD-related problems, but instead quickly or gradually moderate their AOD through the process of maturation and the assumption of adult responsibilities (Fillmore, et al, 1988).

**Moderation Societies** are mutual aid societies that seek to resolve alcohol-related problems by moderating rather than ceasing alcohol consumption. More specifically, these societies set limits for their members on the quantity, pacing, frequency, location and rituals involved in alcohol consumption. Such societies date from the sixteenth century in Europe (Germany) and the nineteenth century in the United States (Cherrington, 1928). The core themes of the currently most popular moderation society in the United States, Moderation Management (Kishline, 1994) are moderation, balance, self-control ("self-management") and personal responsibility.

**Motivational Interviewing** is a non-confrontational approach to eliciting recovery-seeking behaviors that was developed by William Miller and Stephen Rollnick. The approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defense structure), rolling with resistance (emphasizing respect for the individual experiencing the problem and their necessity and ability to solve the problem), and supporting self-efficacy (expressing confidence in the individual's ability to recovery and expressing confidence that they will recovery). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to "hit bottom" and an alternative to confrontation-oriented intervention strategies (Miller and Rollnick, 1991).

**Multiple Pathways of Recovery (Multiple Pathway Model)** reflect the diversity of how individuals resolve problems in their relationship with alcohol and other drugs. Multiple pathway models contend that there are multiple etiological pathways into addiction that unfold in highly variable patterns, courses and outcomes; that respond to quite different treatment approaches; and that are resolved through a wide variety of recovery styles and support structures (White, 1996). Multiple pathways models have moved from the addiction arena into the recovery advocacy arena. Groups like the Santa Barbara, CA Community Recovery Network openly proclaim themselves: *...an advocacy organization whose primary purpose is to fully represent the recovery community in its diversity. As such, we have no bias or formal opinion concerning the manner or means by which people achieve or maintain recovery*. (The Nature of Recovery, 2002)

**Mutual Aid Groups** are groups of individuals who share their experience, strength and hope about recovery from addiction. Often called "self-help" groups, they more technically involve an admission that efforts at self-help have failed and that the help and support of others is needed (Miller and Kurtz, 1994). Mutual aid groups are based on relationships that are personal rather than professional, reciprocal rather than fiduciary, free rather than fee-based, and enduring rather than transient (See Indigenous Healers and Institutions).

**Natural Recovery** is a term used to describe those who have initiated and sustained recovery from a behavioral health disorder without professional assistance or involvement in a formal mutual aid group. This type of resolution of alcohol and other drug problems has been variously christened "maturing out" (Winick, 1962, 1964); "autoremission" (Vaillant, 1983; Klingeman, 1992); "self-initiated change" (Biernacki, 1986); "unassisted change" (McMurran, 1994; "spontaneous remission" (Anthony and Helzer, 1991); "de-addiction" (Klingeman, 1991); "self-change" (Sobell, Sobell, and Toneatto, 1993); "natural recovery" (Havassey, Hall and Wasserman, 1991; "self-managed change" (Copeland, 1998) and "quantum change" (Miller and C'de Baca, 2001)

**The New Recovery Advocacy Movement** depicts the collective efforts of grassroots organizations of recovered/recovering people and their families whose goals are to 1) provide an unequivocal message of hope about the potential of long term recovery from behavioral health disorders, and 2) to advocate for public policies and programs that help initiate and sustain such recoveries. The core strategies of the New Recovery Advocacy Movement are 1) recovery representation, 2) recovery needs assessment, 3) recovery education, 4) recovery resource development, 5) policy (rights) advocacy, 6) recovery celebration, and 7) recovery research (White, 1999).

**Paradox**, the extraction of meaning from an apparent incongruity is a common recovery experience, e.g., to get it, you must give it away; when you think you're looking good, you're looking bad; you can find serenity

when you stop looking for it. Such qualitative dimensions of recovery defy capture in the rush to bridge the gap between clinical research and clinical practice in addiction treatment.

**Partial Recovery** is 1) the failure to achieve full symptom remission (abstinence or the reduction of AOD use below problematic levels), but the achievement of a reduced frequency, duration, and intensity of use and reduction of personal and social costs associated with alcohol/drug use, or 2) the achievement of complete abstinence from alcohol and other drugs but the failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery may precede full recovery or constitute a sustained outcome (See Emotional Sobriety, Wellbriety).

**Partnership Model** is the term used to distinguish the nature of the service relationship in the recovery management model from traditional "expert" models of problem intervention. Partnership implies a more enduring relationship and one with greater mutuality of rights and responsibilities.

**Pathways (to Addiction and Recovery)** is a phrase that connotes the movement into and out of addiction and into (and potentially out of) recovery. The image of pathways conveys the notion of choices that ultimately shape one's personal destiny. There have been many advocates of single pathway models of addiction and recovery: addiction is caused by one thing, unfolds in a highly predictable and homogenous pattern, responds to a narrow approach to treatment, and remains in remission through a singular approach to recovery management. Single pathway models are being replaced by multiple pathways models: there are many etiological pathways to alcohol and other drug problems; these problems unfold in highly diverse patterns and vary considerably in their course; different types of AOD problems respond to different intervention approaches; and there are multiple pathways and styles of resolution for AOD problems. (See Roads to Recovery)

**Peyote Way (Peyote Road; Tipi Way)** is a sobriety-based ethical code of conduct associated with the Native American Church. Having been used as a recovery support structure by Native Americans for more than a century, the Peyote Way demands certain practices: faithfulness in marriage, fulfillment of kinship duties, brotherly love, hard work, generosity, and abstinence from alcohol (LaBarre, 1976; Slotkin, 1956).

**Powerlessness** is the acknowledgement of one's inability to control the frequency and quantity of alcohol or drug intake and its consequences through an act of personal will.

**Prayer** (See Centering Rituals)

**Preferred Defense Structure** is a concept first proposed by John Wallace (1974). Wallace was an early proponent of the idea that there are developmental stages in the transition between alcoholism and long-term recovery. It was his observation that some forms of the primitive defense mechanisms used to sustain addiction (denial, minimization, projection of blame, "either-or" thinking) were needed to get through early recovery, but that these same mechanisms (collectively christened, "preferred defense structure") had to be given up for long-term recovery. He suggested that interventions that were effective at one stage of recovery might be ineffective or even harmful at other stages. For example, interventions that weakened this preferred defense structure in early recovery could inadvertently increase the risk of relapse.

**Program** has come to have many meanings within American communities of recovery. It has come to be synonymous with Twelve Step recovery, as "How long have you been in the Program?" and with the Twelve Steps, as in "I've been in AA for quite a while but I've only been working the Program (the Steps) this past year." Program has also taken on

a more generic meaning for any codified approach to addiction recovery. The Handbook of LifeRing Secular Recovery suggests that there are two broad approaches to recovery frameworks: the big-P through which a person addicted to alcohol or other drugs surrenders themselves to the prescriptions others have earlier followed to achieve recovery, and the little-p that creates an environment of safety and mutual support within which each person works out his or her own, highly personalized approach to recovery (A Handbook of Secular Recovery, 1999).

**Program Tripper** is a person who is simultaneously or sequentially involved in two or more recovery support programs. While the term was used to disparage such practice, there is considerable evidence that such combinations are common, e.g., members of AA also involved in psychotherapy, members of WFS, SOS, and MM also involved in AA, and members of these groups who later attend support groups for problems other than addiction (See serial recovery).

**(The) Promises** refer to the fruits of recovery that could be expected by working the Twelve Steps of Alcoholics Anonymous:

*If we are painstaking about this phase of our development, we will be amazed before half through! We are going to know a new freedom and happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves. Are these extravagant promises? We think not. They are being fulfilled among us--sometimes quickly, sometimes slowly. They will always materialize if we work for them.* (Alcoholics Anonymous, p. 96, first edition)

**Public Health Model** is an approach to the resolution of alcohol and other drug problems that shifts the focus from the personal arena (recovery) to the environmental (economic, political, cultural) arena, e.g., lowering total per capita drug consumption within a population via product taxation, limiting number of outlets, restricting product promotional activity, public education, etc. Public health model proponents address many contextual issues historically ignored by the treatment and recovery communities.

**Purification** is a ritual of cleansing long associated with Native American alcoholism recovery practices. Purification rituals include isolation, fasting, sexual abstinence, purging, and sweating.

Qualify is the term used to describe the process of disclosing one's addiction and recovery experiences within the context of a recovery mutual support group.

**Quantum Change** (See Conversion)

**Rebirth**... (See Born Again)

**Recovered** / **Recovering**... (Abstracted from White, 2001b) are terms used to describe the process of resolving, or the status of having resolved, alcohol and other drug problems. The former is drawn primarily from recovery mutual aid groups; the latter is drawn primarily from the treatment industry. Recovered is drawn primarily from the Individuals who have resolved such problems have been referred to as redeemed (or repentant) drunkard, reformed drunkard, dry drunkard, dry (former) alcoholic, arrested alcoholic, sobriate, ex-addict, and ex-alcoholic. 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 for a permanent resolution of alcohol and other drug problems. Achieving both utilities may require that one language be used inside recovery circles while another language is used to speak publicly. The terms “seeking recovery,” “in recovery” and “recovering” could 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.

**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. It is the achievement of optimum health–the process of rising above and becoming more than an illness (Deegan, 1988, 1996; Anthony, 1993). Recovery, in contrast to treatment, is both done and defined by the person with the problem (Diamond, 2001). “Recovery” implies that something once possessed and then lost is reacquired. The term recovery promises the ability to get back what one once had and as such holds out unspoken hope for a return of lost health, lost esteem, lost relationships, lost financial or social status. Recovery, in this sense, is congruent with the concept of rehabilitation–the reacquisition of that which was lost. For those who have pre-existing levels of functioning that were lost to addiction, there is in the term recovery the promise of being able to reach back and pick up the pieces of where one’s life was at before addiction altered one’s life course. For those who never had such a prior level of functioning, the term recovery may be more aptly framed “procovery” or “discovery”–the movement toward that which is new. For those wounded by childhood victimization, the term “uncovery” may be an apt description of the early healing process (White and Chaney, 1993). This reaching back and reaching forward represent two very different positions from which recovery is initiated, and mark the differences between treatment approaches based on rehabilitation versus those based on habilitation.

**Recovery Activism** is the use of personal recovery experiences as a springboard for economic, political and social change. Recovery activism seeks redress of environmental conditions that contribute to addiction or constitute a barrier to recovery.

**Recovery Advocacy** is the process of exerting influence (power) toward the development of pro-recovery social policies and programs. Recovery advocacy activities 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 attempt to dehumanize and demonize those with AOD problems, 4) enhancing the variety, availability, and quality of local/regional addiction treatment and recovery support services, 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, and 6) enhancing the viability and strength of indigenous communities of recovery.

**Recovery Assets** (see Recovery Capital)

**Recovery-bonded Relationships** are relationships that are grounded on the shared experience of recovery. They elevate and deepen the recovery experience, and serve as a replacement for the pathology-bonded relationships that often existed as a

centerpiece of the addiction experience. These special people go by many names: sponsor, mentor, role model, and, most importantly, friend (White, 1996).

**Recovery Capital** is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-disordering condition (Granfield & Cloud, 1999). In contrast to those achieving natural recovery, most clients entering addiction treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help (See Habilitation).

**Recovery Career** is a way of conceptualizing the stages and processes involved in long term addiction recovery. The concept of "career" has been used to describe the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, et al, 1997). Recovery career is an extension of this application and refers to the evolving stages in one's identity, one's relationships with others, and, in some cases, styles of involvement with mutual aid groups. There could, for example, be significant changes in the perceived meaning and application of AA's Twelve Steps over the long course of a recovery career.

**Recovery Celebration** is an event in which recovered and recovering people assemble to honor the achievement of recovery. Such celebrations serve both therapeutic and mutual support functions but also (to the extent that such celebrations are public) serve to combat social stigma attached to addiction by putting a human face on addiction and by conveying living proof of the enduring resolution of alcohol and other drug problems.

**Recovery Coach (Recovery Support Specialist)** is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community, and serves as a personal guide and mentor in the management of personal and family recovery. Such supports are generated through mobilizing volunteer resources within the recovery community, or provided by the recovery coach where such natural support networks are lacking.

**Recovery Community (Communities of Recovery)** is a term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both professionals working in the behavioral health fields as well as recovery supporters within the wider community. Recovery management is based on the assumption that there is a wellspring of untapped hospitality and service within this recovery community that can be mobilized to aid those seeking recovery for themselves and their families. "Communities of recovery" is a phrase coined by Ernest Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a reciprocity of "fit." The growth of these divergent communities reflects the growing varieties of recovery experiences (Kurtz, 1999).

**Recovery Consultant** (see Recovery Coach)

**Recovery Deficits** are the specific internal and external obstacles that impede initiating or maintaining a solution for AOD-related problems. The notion of recovery assets and deficits suggests two very different approaches to the process of recovery priming. One focuses on reducing obstacles to recovery; the other focuses on increasing internal and external recovery resources.

**Recovery Demography** is the study of populations of people who have resolved alcohol and other drug-related problems. Such studies are generally done through population surveys, surveys of recovery

mutual aid societies or recovery advocacy organizations, and through longitudinal follow-up studies of people who have been treated for alcohol and other drug problems. The major purposes of such surveys are to measure the incidence and prevalence of recovery and the variations in recovery across various demographic and clinical categories. (See www.recoveryadvocacy.org for a sample of a recent recovery survey.)

**Recovery Environment (Space, Landscape)** is a term that stands as a reminder that recovery flourishes in communities that build the physical, psychological and social space where healing can occur. It stands as a reminder that communities can intervene in alcohol and drug problems at the community level as well as the level of families and individuals. The growing sober house movement and the creation of drug free zones within public housing projects are examples of efforts to create sober sanctuaries for the newly recovering (See Ecology of Recovery).

**Recovery Home** is a self-managed, self-funded communal living environment for people in stage one recovery. The Oxford Houses are the best known and researched system of recovery homes in the United States (Jason, Davis, Farrari, and Bishop, 2001)

**Recovery Identity** is the degree to which one self-identifies with the statuses of addiction and recovery and the degree to which one initiates and sustains recovery in isolation from or in relationship with other recovering people (See Affiliated Recovery, Solo Recovery).

**Recovery Management** is the provision of engagement, stabilization, education, monitoring, support, and re-intervention technologies to maximize the health, quality of life and level of productivity of persons with severe alcohol and other drug problems. Within the framework of recovery management, the "management" of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant (see Illness Self-Management).

**Recovery Needs Assessment** is the solicitation of information on the needs of people at different stages of recovery. While the identification of such needs can be done through formal surveys, they are most frequently conducted by focus groups hosted by local recovery advocacy organizations or through interviews conducted by outreach workers.

**Recovery-oriented Systems of Care** are health and human service institutions that affirm hope for recovery, exemplify a strengths-based (as opposed to pathology-focused) orientation, and offer a wide spectrum of services aimed at support of long term recovery from behavioral health disorders.

**Recovery Outcomes** refers to the degree of benefits achieved as a consequence of recovery from addiction. Discussions of recovery outcome rest on the understanding that not all recoveries are the same and that the term "recovery" embraces everything from the removal of alcohol and drugs from an otherwise unchanged person to the total transformation of personal identity, character and lifestyle. Recovery outcomes might also be referred to as recovery-generated assets.

**"Recovery Porn"** is a term of contempt for items or services aggressively marketed to people in recovery with the primary purpose being the profit of the seller rather than the recovery of the buyer. The term is a reminder that there are moneychangers in the temple of recovery, and that people in recovery need to protect themselves from potential exploitation.

**Recovery Planning and Recovery Plans**, in contrast to a treatment plan, is developed, implemented, revised and regularly evaluated by the client. Consisting of a master recovery plan and weekly implementation plans, the recovery plan covers ten domains: physical, employment,

finances, legal, family, social life, drinking, personal, education and spiritual. Recovery plans were pioneered within the "social model" programs of California (Borkman, 1998).

**Recovery Priming** is the process of helping someone move from an addiction career to a recovery career. It is the sudden or cumulative achievement of recovery momentum. Within stages of change theory, it is moving someone from a precontemplation stage of change to an action stage of change. It most often involves exposure to recovery role models with whom one can identify, the removal of recovery obstacles, the affirmation of hope in recovery and the expression of confidence in the individual's ability to recovery (see Developmental Models of Recovery). It also refers to the process through which mastery of one self-destructive behavior (alcoholism) enhances the prospects of resolving other destructive behaviors (e.g., nicotine addiction).

**Recovery Progression** Is the idea that there are natural stages within the addiction recovery process (see Developmental Model). Simonelli (2002) has suggested that this progression moves from addiction to sobriety to recovery to wellness.

**Recovery Representation** refers to the involvement of recovering people and their family members in addiction-related public policy bodies and their involvement in the design, delivery, and evaluation of addiction treatment and recovery support services.

**Recovery Research (Agenda)** is an effort to balance problem-oriented research activity with solution-oriented research activity. A recovery research agenda could document the prevalence of recovery, create a cartography of pathways and styles of recovery, define the stages of long term recovery, identify those support services most crucial to long term recovery, measure dose and matching effects of such services, document variations in recovery patterns across various demographic and clinical subpopulations, and document the social and economic benefits of recovery. (See Recovery Demography)

**Recovery Rights** address problems of discrimination against people in addiction recovery. Issues included within this arena span discrimination in housing, employment, access to public services, health and life insurance, and scholarship funds for vocational training and college and universities.

**Recovery Rituals** are activities through which recovery from addiction is enhanced. The multiple pathways of recovery often share four core daily activities: centering rituals, mirroring rituals, acts of self-care, and unpaid acts of service.

**Recovery Support Groups (Mutual Aid Groups)** are groups of recovering people who meet regularly for fellowship and mutual support. See www.bhrm.org/Guide.htm for a recovery mutual aid guide developed and maintained by Ernest and Linda Kurtz. See White 1998 & 2001a for a history of such groups in the United States.

**Recovery Support Services** are services designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life in recovery. They include outreach, intervention and engagement services; "case management" (problem-solving and service coordination) services; post-treatment monitoring and support; sober housing; transportation; child care; legal services; educational/vocational services; linkage to pro-recovery leisure activities; and recovery coaching (stage appropriate recovery education and support).

**Recovery Support Specialist** (See Recovery Coach)

**Recovery Values** are those virtues that have come to be associated with recovery from addiction. Variable across recovery

pathways, a sampling of such values can be found in Native adaptations of the Twelve Steps: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

**Red Road to Sobriety** is a Native American Framework of recovery developed by Gene Thin Elk (Lakota-South Dakota). The term, "Red Road" has come to mean a style of sober living that, rather than just the absence of drinking, reflects internal peace and living with respect and in harmony with others and the earth (see Wellbriety).

**Redeemed, Redemption, Repented, or Repentance** is the resolution of alcohol and other drug problems through an experience of rebirth. In this model of understanding, the addicted self dies and the new drug-free self is born. ("Therefore, if any man is in Christ, he is a new creation, old thing have passed away; behold, all things have become new." 2 Corinthians 5:17)

**Relational culture (power)** is an organizing principle used by some recovery advocacy groups to mobilize the recovery community. The principle is based on enhancing mutual identification by consciously exploring (cultivating mindfulness) the shared experiences and needs of people who have been impacted by addiction. The strategy involves conducting series of intentional conversations designed to enhance the consciousness of people in recovery and bring such people together for joint reflection and action.

Religion is a system of beliefs about the nature of the universe, the nature of ultimate concerns in life and the, meaning of personal destiny, all of which are affirmed through creeds, prescriptions for living, and rituals of worship. Religions of many varieties have provided, and will continue to provide, a framework for addiction recovery. While some people use religious experience to initiate recovery, others use religious affiliation and worship to sustain and enrich their recovery.

**Renounce/Renunciation**
(see Commitment)

**Reprieve** (versus Cure) is one way of understanding the means through which recovery is attained. In this understanding, recovery is a daily suspension of addiction contingent upon recovery self-management: doing what is necessary to, and avoiding what would undermine, the stability and durability of recovery. There is a second and broader meaning to the term reprieve. In confronting the imminence of death through the experience of addiction, there is often an awareness that every day of life is a reprieve, regardless of one's health status. What that awareness encourages is a fidelity to personal priorities and the achievement of meaning and pleasure within the confines of each day. When recovering people characterize their addiction as a hidden blessing, it is often in gratitude for this kind of awareness

**Resistance** (Recovery as an act of) is the framing of addiction, not as an act of surrender, but as an act of personal and cultural assertion. It is a refusal to be silenced by self-destruction. In this framework, recovery is a conscious entry into struggle on behalf of oneself and a larger cultural community (See Genocide).

**Resolution** (versus Recovery) is a term preferred by some for the process of solving alcohol and other drug problems. Resolution, resolving and resolved are less medicalized terms. For those who wish to reserve use of the term recovery to the reversal of severe AOD problems or to abstinence-based recovery, the term resolution might be a more preferable term applied to those who work out non-abstinent solutions to less severe and less enduring AOD problems. (See Moderated Recovery) Another use of the term "resolution can be found in Dr. William Silkworth's (1937) distinction between a resolution not to drink and a decision not to drink. Silkworth noted that a resolution was a "momentary emotional desire to reform," whereas a

decision is an attitude-transforming mental conclusion and conviction that one must never drink again. He suggests that resolutions based on appeals to emotion must be replaced with decisions made with one's mind.

**Responsibility** is the acceptance of accountability for past, present and future actions. This value has importance in the context of recovery as the antidote for projection of blame and other strategies of defense characteristic of active addiction.

**Restitution** is the process of rectifying wounds inflicted on individuals and the community (see Amends)..

**Resurrection** (as a metaphor of recovery) dates to the Washingtonian Temperance Society, which was also sometimes referred to as the Lazarus (or Resurrection) Society. References to the resurrection of addicted people through the act of recovery continue into the present era (see Williams, 1992, p. 81).

**Rituals of Recovery** Include centering rituals, mirroring rituals, acts of responsibility, and unpaid acts of service.

**Roads to Recovery** is a phrase first used by Bill Wilson to convey the diversity of ways used to escape alcoholism. When some AA members criticized the inclusion of a story in the A.A. Grapevine of a celebrity writer who achieved solo recovery (no involvement in AA), Wilson responded by declaring, "The roads to recovery are many" and that the resolution of alcoholism by any method should be a cause for celebration by A.A. members (Wilson, 1944) (see Pathways to Recovery).

**Secular Recovery** is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or religious rituals (prayer). Groups providing support for a secular style of recovery include Secular Organization for Sobriety, LifeRing Secular Recovery, and Rational Recovery.

**Serial Recovery** is the process through which individuals with multiple concurrent or sequential problems resolve these problems and move toward optimum level of functioning and quality of life. Serial recovery refers to the process of sequentially shedding two or more drugs or recovering from two or more different conditions. It refers to the overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders. (See Sobriety Date)

**Service Committees** are the structures within mutual aid societies through which members support the organizational work of the societies and render help to those still suffering from addiction.

**Service Work** (see Acts of Service)

**Sharing** is the stylized form of communication common within many recovery mutual aid societies. It is well described in the Handbook of Secular Recovery.

*"Sharing" has a very definite meaning in self-help groups...The person talks, everybody else listens. Then the next person talks, and everybody listens. Then the next. At no point is anybody's "share" an answer or other direct response to anyone else's. Each share stands entirely on its own, complete and sufficient unto itself....The "no response" rule of sharing time protects the speaker from having their statement judged, criticized, ridiculed, or otherwise attacked. This in turn promotes the fullest possible openness and honesty..."* (Handbook of Secular Recovery, 1999, pp. 30-31). (See Crosstalk)

**Sin** is a designation of the state of addiction as defined by groups like Alcoholics for Christ: "We agree that drunkenness is a sin and we believe that alcoholism is a disease with spiritual origins. We rejoice that Jesus forgives us of our sins and heals us of our diseases."

**Slogans** are a shorthand method of communicating to oneself and others in recovery. They are phrases that that have come to embody certain recovery principles and prescriptions. While they inspire some and irritate others, they have become a visible symbol of American communities of recovery, widely heard in recovery dialogue and widely seen on posters and bumper stickers. They represent a form of meditative mantra (self-talk) at the same time they serve as a kind of in-group code through which recovering people find each other when mixed with civilians.

**Sober House Movement** refers to the dramatic expansion of recovery communes (self-run residences where people (often in early recovery) can live in a recovery-supportive living environment. (See Recovery Home)

**Sobriety-based Support Structure** is a social network of people who share and support recovery from alcohol and other drug problems. Such affiliation, whether religious (churches), spiritual (A.A./N.A.) or secular (W.F.S., S.O.S), offers a "program" of recovery that includes reasons and methods of altering one's pattern of alcohol/drug consumption within a larger change in one's philosophy of living.

Sobriety ("Clean") Date is traditionally defined as the anniversary date of one's last drink or episode of drug use. Such calculations are not always clear-cut. Let's take an individual who was addicted to methamphetamine, stopped using it completely after a near-death experience at age 21, increased cannabis use for 18 months and then stopped that out of concern that it was getting to be a problem, developed an alcohol problem following a divorce at age 34, and stopped a 2-pack a day nicotine addiction at age 45. From age 22 on, they have also been episodically treated for depression. What is this individual's sobriety/recovery date? This not atypical story reveals the way in which many recovering people peel drugs out of their lives over a period of time and manage recovery from addiction in tandem with recovery from other co-occurring problems. While a sobriety date provides a quantitative measure of the length of symptom remission for one problem, it misrepresents the often complex processes involved in recovery and provides little information on the quality of sobriety measures. Families in recovery often speak of recovery date rather than sobriety date, although such a date is often difficult for families to pinpoint. Some family members place their recovery date at a crisis that led to their decision to get help, a moment of breakthrough during a counseling session or an Al-Anon meeting, or a period in which they began to see and tell the truth about what was happening in their family. (See Serial Recovery).

**Sobriety Priority**, in Secular Organization for Sobriety and LifeRing Secular Recovery, is the decision to never use alcohol/drugs again in one's life, no matter what (Christopher, 1988, 1992; Handbook of Secular Recovery, 1999). It is analogous to what in Rational Recovery is called the "Big Plan" (Trimpey, 1989).

**Sobriety Sampling** is an experimental period of abstinence designed to test one's capability for, and the experience of, abstinence. It is an action stage of problem resolution that stops short of, but can potentially lead to, a lifetime commitment to abstinence (Miller and Page, 1991) (See Tapering Down and Trial Moderation)

**Solo Recovery** is the initiation and maintenance of recovery from addiction without involvement in professionally-directed treatment or recovery mutual aid societies (see Natural Recovery).

**Spheres (Zones, Domains) of Recovery** are the life arenas through which the recovery process is expressed. One can thus speak of physical recovery, family and relational recovery, social recovery, economic recovery, etc. (Ron Coleman).

**Spiritual (Spirituality)** (Abstracted from White, 1992) is a heightened state of

perception, awareness, performance or being that personally informs, heals, empowers, connects or liberates. For people in recovery, it is a connection with resources within and outside the self. There is a spirituality that springs from pain, a spirituality that springs from pleasure, and a spirituality that can flow from the simplicity of daily life. The power of the spiritual to draw us beyond our normal range of experience is evident in the language of non-ordinary experience: awakening, rapture, peak experience, defining moment, epiphany, rebirth, ecstasy (see Hitting Bottom, Conversion). The spirituality of fully experiencing the subtlety and depth of the ordinary is depicted in such terms as harmony, balance, centeredness, bliss, serenity, and tranquility. All of these can be part of the multi-layered experience of addiction recovery.

**Spiritual Awakening** refers to the progressive changes in character and relationships that recovering people experience through the stages of recovery. Such an incremental process of change is also commonly described as a spiritual "experience." This gradual awakening stands in contrast to a sudden conversion).

**The Spirituality of Imperfection** is a recognition that human beings are flawed and make mistakes of various kinds. It is in this recognition and deep acceptance of one's own imperfection that a new awareness emerges–the recognition and acceptance of the imperfection of others. It is in this second step that the alcoholic finds a framework for identification and relationship with the larger body of humanity (Kurtz, 1999).

**Sponsorship** is the practice of mentorship between one recovering person and another. It has a long tradition dating to the Washingtonians (1840s), has been most institutionalized within Alcoholics Anonymous and Narcotics Anonymous, and is also found within many faith-based recovery groups. The latter refer to sponsorship as the "ministry of encouragement."

**Stability/Durability (of recovery)** refers to the duration of time at which recovery and its continuation become quite likely, and the risk of relapse grows quite remote. The concepts of stability and durability are to distinguish true recovery from the self-imposed respites from alcohol and other drug use that are a normal part of addiction careers. Research studies have generally defined 3-5 years as this point of predictive stability and durability (Vaillant, 1996; Nathan and Skinstad, 1987; De Soto, et al, 1989; Dawson, 1996; and Jin, et al, 1998)

**Stage One Recovery**, according to Ernie Larsen who coined the Stage One–Stage Two distinction, is the process of breaking a primary addiction (Larsen, 1985, p. 4). Picucci (2002) describes it as the early years of reducing chaos, achieving stability, learning to accept help from others, and clearing out the wreckage of the past.

**Stage Two Recovery** (according to Larsen) involves "rebuilding the life that was saved in Stage I" (Larsen, 1985, p. 15). Stage Two Recovery transcends the early concern with the addictive behavior and instead focuses on a reconstruction of personal character, identity, and worldview and a reconstruction of personal relationships.

**Story Construction / Storytelling** is the process through which the recovering individual reconstructs their identity and shares their experience with others as acts of self-healing and service. Nearly all recovery stories–sacred and secular--follow a three-part sequence of the development of addiction, the turn-around-experience, and an account of life in recovery (White, 1996) (See Witness/Testify).

**Styles of Recovery** is a phrase that reflects the many varieties of ways people successfully approach the management of behavioral health disorders. These styles reflect the different ways in which identification with the disease and the

recovery process becomes part of one's identity and the degree to which one relates to other people who share this recovery process (See acultural, bicultural and enmeshed). Styles also reflect temporal variations in recovery: recovery as a sudden transformational process ("Quantum Change", Miller and C' de Baca, 2001) versus incremental change (Procahska, et al, 1992)

**Surrender**, according to Dr. Harry Tiebout's (1949) classic paper on the subject, is the collapse of "the unconscious forces of defiance and grandiosity" and "accepting without reservation or conflict the reality of his condition and his need for help." Tiebout noted that such a collapse could mark the beginning of a process of continuing change or could be an ephemeral experience followed by a rigid, primitive hold on sobriety or a return to drinking and the resurgence of defiance and grandiosity. He noted that true surrender was followed not just by sobriety but "internal peace and quiet." While experiences of acceptance, powerlessness and surrender mark the very core of the change process in Twelve Step recovery, recovery programs for historically disempowered groups often emphasize the self-assertion rather than surrender (see Empowerment).

**Tapering Down** is a strategy of lowering frequency and quantity of drug consumption either as an end in itself or in preparation for a final quit date. The strategy is designed to lower pharmacological tolerance, ease acute withdrawal at the point of quitting, and serve as a recovery priming experience (Miller and Page, 1991).

**Temple (Body as)** is a Christian recovery concept in which the human body is viewed as the temple of God. The concept calls for respect for that temple via refusal to defile that temple with poisons (alcohol and other drugs).

**Traditions** are the codified principles that govern the group life of Twelve Step organizations. Such principles, which have been cited as a source of A.A.'s resilience (White, 1998), have varied by their presence or absence and their content in recovery mutual aid societies. Most recovery mutual aid societies have evolved toward a tradition of singleness of purpose and non-affiliation, while there are significant differences across these societies on issues related to such things as anonymity, service expectations and length of expected active membership.

**Trauma of Recovery** is a phrase coined by Stephanie Brown and Virginia Lewis (1999) to depict the strain of unfreezing the adaptive mechanisms used to maintain family homeostasis in the face of active addiction and the resulting impairment of other family members. The phrase vividly conveys the enormous changes in family structure and process that unfold with recovery. It conveys that the achievement of family health following the initiation of recovery is best measured in years rather than months, and it conveys the family's need for support during these critical points in the recovery process.

**Trial Moderation** is a strategy used with persons who reject abstinence as a necessary goal. The strategy consists of establishing a test period in which an individual seeks to consume within prescribed guidelines of frequency, quantity and contexts. A long-term (3-8 year) follow-up study of such trials among problem drinkers revealed that more than half eventually choose abstinence (Miller and Page, 1991; Miller et al, 1992). This strategy was actually recommended in the book Alcoholics Anonymous:

> *We do not like to brand any individual as an alcoholic, but you can quickly diagnose yourself. Step over to the nearest barroom and try some controlled drinking. Try to drink and stop abruptly. Try it more than once. It will not take long for you to decide, if you are honest with yourself about it. It may be worth a bad case of jitters if you get a full knowledge of your condition* (p. 43, first edition)

**Triggering mechanisms**, in contrast to the oft-noted relapse triggers, are experiences that spark the initiation of sobriety experiments (Humphreys, et al, 1995). These may build cumulatively toward stable recovery or be unleashed in a single, conversion-like experience (See Developmental Stages of Recovery, Conversion; Initiating Factors).

**The Twelve Concepts** depict the service structure within Alcoholics Anonymous, particularly the relationships between the A.A. World Services Office, the General Service Board and Conference, and local A.A. groups.

**Twelve Principles** are the values imbedded within the Twelve Steps. There have been several efforts to briefly catalogue these values/virtues/experiences. One version is: 1) Surrender, 2) Hope, 3) Commitment, 4) Honesty, 5) Truth, 6) Willingness, 7) Humility, 8) Reflection, 9) Amendment, 10) Vigilance, 11) Attunement, and 12) Service. Another version is: 1) Honesty, 2) Hope, 3) Faith, 4) Courage, 5) Integrity, 6) Willingness, 7) Humility, 8) Brotherly Love, 9) Justice, 10) Perseverance, 11) Spiritual Awareness, and 12) Service.

**(The) Twelve Steps** are the actions taken by the early members of Alcoholics Anonymous that resulted in their continued sobriety and which were subsequently suggested as a program of recovery for other alcoholics. The Twelve Steps are reproduced in virtually all A.A. literature and have been adapted for application to a wide spectrum of human problems. .

**Twelve Traditions** (See Traditions)

**Varieties of Recovery Experience** is a term Ernest Kurtz adapted from William James writings to convey the growing diversity of recovery styles within A.A. as well as the growth in alternative (non-Twelve-Step) frameworks of addiction recovery.

**Virtual Recovery** is the achievement or maintenance of recovery through Internet support groups and with little or no participation in face-to-face support meetings.

**(Achieving) Visibility (or Voice)** is the process through which historically disempowered people become seen and heard as they take responsibility for their own recovery. Recovery thus becomes an antidote to silence and invisibility. Visibility is achieved by standing as a witness and offering testimony to one's return to life (Williams, 1992). (See story construction / story telling).

**Wellbriety** is a term coined by Don Coyhis (1999) that depicts recovery as more than just symptom suppression. The term implies the pursuit or achievement of global (physical, emotional, intellectual, relational, and spiritual) health, or "whole health." (Red Road to Wellbriety, 2002). It is analogous to what AA co-founder, Bill Wilson, described as "emotional sobriety" (Wilson, 1958)

**Witness (testify, testimony)** is the act of telling one's story as an act of service, whether the target of that story is an individual, a community or a culture.

**Wounded Healers** are people who, having survived a life-threatening and life-transforming illness/experience, help guide others through this same illness/experience. There is a rich tradition of wounded healers that reaches far beyond the history of addiction recovery (White, 2000a, 2000,b).

**Zones (or Domains) of Recovery** are the arenas in which recovery processes unfold. These have been differentiated as zones of action and experience. The zones include physical recovery, psychological recovery, spiritual recovery, relational recovery, and lifestyle (occupational, financial, recreational) recovery (White, 1996),

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## A Brief Primer on Recovery Management (RM)

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### Definition

Recover management (RM) is the time-sustained stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is collaborative model between service consumers and traditional and non-traditional service providers aimed at stabilizing and then actively managing, the ebb and flow of one or more chronic disorders

### Distinguished from "Treatment"

Recovery management differs from traditional treatment by: 1) lowering the threshold of service entry and continued service involvement (truly meeting the individual/family where they are) 2) redefining the role of the professional from one of expert "treater" to that of a long-term consultant and ally and redefines the role of the consumer from "patient" to the leader of the recovery management team, 3) shifting the emphasis from crisis stabilization to sustained management of the disorder via the linkage of treatment with a sustained continuum of recovery support services, 4) incorporating peers and indigenous healers/institutions into the service team, 5) re-engineering assessment to a process that is global (rather than categorical) and continual (rather than an intake function), 6) emphasizing sustained monitoring, stage-appropriate recovery education and recovery support services, linkage to the natural resources of communities of recovery, and, if and when necessary, early re-intervention, and 7) evaluating service events based not on their short-term effects but on their impact on the course of one's recovery career[1].

### Distinguished from "Disease Management"

Recovery management has much in common with early service initiatives characterized as "disease management" (DM) approaches but the selection of the term "recovery management"

[1]Recovery career is the total span of experience that occurs after recovery from a severe behavioral health disorder has begun. It assumes that events that have short term effects on the course of a disorder may not have equally potent long term effects and that experiences that may not have short term effects may generate potent (cumulative or synergistic) long-term effects.

indicated the desire to focus on the experiences, needs and aspirations of the individual/family rather than the management of costs which many DM models have come to emphasize. In RM, the individual/family experiencing the disorder are the one's doing the managing (rather than being "managed") and the primary goal of such management is their own quality of life. In RM, any cost-reductions achieved by this model are desirable side-effects, but not its primary purpose.

**Elements of Recovery Management**

There are seven elements to a comprehensive program of recovery management:

1) Assessment of Needs and Resources (identifying the needs and strengths of individuals/families experiencing severe behavioral health disorders with a particular emphasis on eliciting first-person voices)
2) Recovery Coalition and Recovery Community Building (linking personal, professional and indigenous community resources into recovery management teams; increasing the service and support capacities pf local communities of recovery,
3) Recovery Resource Development (creating the physical, psychological and social space within a community in which recovery can occur; creating a full continuum of treatment and recovery support services),
4) Recovery Education and Training (enhancing the recovery knowledge and skills of a) people/families in recovery, b) service providers, and c) the larger community
5) Recovery Support Services (removing barriers and enhancing "recovery capital"[2]),
6) Recovery Evaluation/Research (pursuing a recovery research agenda), and
7) Recovery Advocacy (advocating for social and institutional policies that counter stigma and discrimination and promote recovery from severe behavioral health disorders).

**Zones of Recovery Management**

The Recovery management model is based on the recognition that recovery occurs incrementally and episodically across five zones of personal experience: physical, psychological, relational, lifestyle and spiritual. RM models anticipate the ebb and flow of needs within and across these zones and uses progress in one zone to prime improvement in other zones.

**Stages of Recovery Management**

The seven elements of recovery management span three phases in the recovery process: engagement and recovery priming (pre-recovery/treatment); recovery initiation and stabilization (in-recovery/treatment), and recovery maintenance (post-treatment recovery support needs).

**Levels of Recovery Management**

RM can range from a low level of service involvement (e.g., an annual recovery checkup or a quarterly phone call to monitor health status) to a high level of service involvement (e.g., recovery home with high intensity monitoring and recovery coaching).

[2]Recovery capital is the total amount of internal and external resources one can bring to bear to the initiation and maintenance of recovery. The term was coined by Granfield, R. and Cloud, W. (1999) *Coming Clean: Overcoming Addiction without Treatment*. New York: New York University Press.



# Selected Papers of William L. White

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## Behavioral Health Recovery Management: Transcending the Limitations of Addiction Treatment

**William White, M.A., Michael Boyle, M.A., and David Loveland, Ph.D.**

**Abstract**

*The acute model of intervention into substance use disorders is being challenged by models that wrap episodes of professional treatment within a sustained continuum of pre-treatment, in-treatment, and post-treatment recovery support services. This article discusses this shift from acute treatment to sustained recovery management and how this shift will transform the practice of addiction treatment.*

### I. Introduction

Alcohol and other drug (AOD) problems present in both acute and chronic forms. For most people, these problems are of low duration and low to moderate severity, and resolve themselves naturally or through brief professional intervention—often outside the world of specialized addiction treatment. Many of these problems fade in the passage through adolescence into adult family and occupational responsibilities or in the resolution of a later developmental crisis, e.g., divorce, occupational displacement, or death of a loved one. Those with the more chronic form of these problems are distinguished by greater personal vulnerability (family history of such problems, lowered age of onset of regular use), greater problem severity, a cluster of co-occurring interlocked problems, and less "recovery capital" (personal, family and social recovery support resources) (Granfield & Cloud, 1999).

The field of addiction treatment has long characterized addiction as a "chronic, progressive disease," but its treatment methods more closely resemble those of the emergency medicine specialist than the chronic disease specialist. If the addiction treatment field truly believed and acted as if addiction constituted a chronic disorder, its practitioners would not:

- cultivate the expectation among clients and family members that full and enduring symptom remission should be achieved from a single episode of treatment,
- view prior treatment "failure" as an indicator of poor prognosis (and historically, grounds for denial of treatment admission),

- "administratively discharge" clients for exhibiting symptoms of the disorder for which they are being treated (e.g., inability to abstain and loss of control over substance use),
- relegate post-treatment aftercare services to an afterthought,
- terminate the service relationship following brief intervention,
- treat serious and persistent alcohol and other drug (AOD) problems in serial episodes of self-contained, unlinked interventions, or
- treat individuals in isolation from the family and social networks that provide the most sustainable support for the management of chronic health problems.

They also would not criticize the few modalities that do offer the option of time-sustained recovery supports (e.g., Alcoholics Anonymous, methadone maintenance) for that very quality. What the field of addiction treatment would do if they really believed addiction was a chronic disorder is the subject of this article.

A series of recent articles (Lewis, 1993; O'Brien & McLellan, 1996; McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002) have challenged the acute intervention model utilized in the treatment of substance use disorders. These articles contend that treating substance use disorders marked by high severity and chronicity via serial, self-contained episodes of screening, assessment, admission, brief treatment followed by discharge and even briefer aftercare is ineffective and results in shaming and punishing clients for failing to respond to a an intervention design that is inherently flawed. More specifically, these articles argue that:

- alcohol and other drug dependencies resemble chronic disorders such as type 2 diabetes mellitus, hypertension and asthma in their etiological complexity (interaction of genetic, biological, psychological and physical/social environmental factors), course, and clinical outcomes;
- personal choice and lifestyle decisions affect the outcomes of all chronic disorders, suggesting the potential application of strategies used to treat other chronic disorders to the treatment of alcohol and drug dependence;
- treating alcohol and other drug dependence via repeated episodes of detoxification and brief stabilization is ineffective and contributes to the therapeutic pessimism of clients, service providers, policy makers and the public; and
- alcohol and other drug dependencies are best treated via models of sustained medical monitoring and continuing care.

Applying the slogan "treatment works" to single episodes of addiction treatment makes no more sense that applying such a slogan to the acute stabilization of a diabetic coma or a hypertensive crisis. The larger question is how such episodes of crisis intervention affect the overall course and outcome of the disorder. For those presenting with the most severe and complex substance use disorders, brief episodes of detoxification and stabilization are more likely to constitute brief respites within one's addiction career than a milestone of entrance into long-term recovery. Changing that status will require fundamentally rethinking how service professionals intervene in the lives of those suffering from these disorders. It calls not for a vision of higher dose crisis intervention (more days/sessions), but a vision of sustained *recovery management*.

**Behavioral Health Recovery Management**

Behavioral Health Recovery Management (BHRM) is the time-sustained stewardship of personal, family and

community resources to achieve the optimal health and functioning of those experiencing severe addiction and/or serious mental illness. As applied to alcohol and drug dependence, the goal of recovery management (RM) is the optimum level of global health and functioning of individuals experiencing such dependence—a goal that for many is achieved by full and sustained symptom remission and for others is achieved by decreasing the frequency and intensity of alcohol and other drug use and its related problems in tandem with lengthened and strengthened periods of remission and recovery. The focus of RM is to empower individuals/families to proactively manage such disorders over their entire course.

The term *recovery management* was coined to depict the process of sustained support through the developmental stages of addiction recovery. This concept grew out of and shares much in common with "disease management" approaches to other chronic health problems, but use of the term recovery management is intended to emphasize the focus on quality of life outcomes as defined by the individual and family. Recovery management shares the disease management goal of effective stewardship of health care resources, but it places a greater value on the achievement of global health and the quality of life of the individual and family. Heavily influenced by new grassroots recovery advocacy organizations, it balances the focus on cost liabilities with the experiences, needs and aspirations of those living with and recovering from addictions. Lowered health care costs, which might well be achieved with this model, are not the primary reason such a model is being advocated.

The principles of recovery management (See Sidebar) mark a shift in how services are designed and delivered, including the timing and duration of such services, the nature of the service continuum, the composition of the service delivery team, and how such services are evaluated.

**The Timing and Duration of Service**

There is a collision going on between clinical characteristics of persons seeking addiction treatment and the administrative/fiscal structures governing such treatment. The multiple problem client/family is becoming the norm, particularly within publicly funded programs. The greater number of presenting problems, the synergistic interaction of these problems, the frequent intergenerational transmission of such problems, and the degree of personal and environmental obstacles to successful recovery would all seem to dictate integrated models of greater service intensity and duration. Yet these clients find not an integrated system of support for initiating and maintaining global health, but a categorically segregating service system whose interventions are becoming ever more brief and fragmented. In this collision between personal needs and systems design, clients are placed in modalities that have little chance of permanently altering the trajectory of their problems and are then blamed for the failures of the systems in which they are enmeshed. This collision also contributes to the demoralization and flight of service staff who feel they have become paper-processors rather than people-helpers. And we have rising therapeutic pessimism fed by the growing number of clients with multiple treatment episodes. (Sixty percent of those admitted to public treatment in the U.S. have been in treatment before, including 24 percent who have been in treatment 3 or more times) (Office of Applied Studies, 2000). The current system of brief intervention with chronic substance use disorders is analogous to treating a bacterial infection with half the needed dose/duration of antibiotic therapy. It may produce temporary symptom suppression, but it can lead to a later resurgence of symptoms, often in a more virulent and treatment-resistant form.

Recovery management reconfigures services by offering an expanded range of services earlier than traditional intervention

occurs and sustaining them long after traditional treatment services have been terminated. Recovery management is not a new rationale for larger doses of residential/inpatient treatment or more outpatient counseling sessions. It is instead a call to wrap these traditional services in a larger web of pre-treatment, in-treatment, and post-treatment recovery support services that are delivered in the community. This is not to say that treatment and recovery support services cannot be delivered in a residential or outpatient setting, but that eventually, people must apply and refine the skills of recovery management in their natural living environments. Recovery management, with its emphasis on building and preserving recovery capital, extends the time over which services are delivered, but shifts the emphasis of these services from high intensity, high cost crisis stabilization services to proactive, lower intensity, and more sustained recovery support services.

**Expanding the Service Continuum**

Recovery management models extend the current continuum of care for addiction by including: 1) pre-treatment (recovery priming) services, 2) recovery mentoring through primary treatment, and 3) sustained post-treatment recovery support services.

As with any chronic disorder, it is assumed that successful self-management of addiction is more likely at earlier than later stages of the disorder. Given the potential for self-acceleration of problem severity and the progressive erosion of internal and external resources, changing the timing of intervention is an important element of the long-term vision of how recovery management might re-shape the current treatment system. The future technologies to achieve this might include primary physician screening, advice, monitoring, feedback and recovery coaching and the mainstream use of outreach services focused on identification, engagement, removing personal and environmental obstacles to recovery, and sustained recovery coaching.

Only a small percentage of people with severe AOD problems seek treatment and of those who do there is a high attrition from initial contact through screening, assessment and admission and even greater attrition when this process involves a waiting list for services. The RM model seeks to infuse front-end, or pre-treatment recovery support services into the community. The goals of such pre-treatment services are to: 1) encourage the self-resolution of AOD problems through natural or mutual aid resources as an alternative to professionally directed treatment, 2) intervene at early stages of problem development before high intensity services are needed, 3) intervene in severe forms of AOD problems before recovery capital is fully depleted, 4) reduce the attrition in sobriety-seeking and help-seeking experiments, 5) help individuals utilize community support systems, and 6) engage individuals within their current developmental stage of change. These services are in short designed to jump-start the recovery process via motivational interventions—what we have come to call *recovery priming*.

There is a high attrition rate among individuals who seek help for AOD-related problems both in professional and mutual aid settings, and it is possible that recovery support specialists could play a role in lowering such attrition. What we are proposing for the professional setting is a form of outreach inside the treatment milieu—the use of recovery support specialists to resolve problems that stand in the way of continued treatment participation. The function would not be treatment per se but the continual re-motivation and re-engagement of those experiencing the ambivalence that is so typical of early recovery.

RM models challenge two dimensions that most represent the acute care model: the concept of discharge (which may occur through “graduation,” administrative discharge, or client

discontinuation of services) and either the lack of post-treatment support services or the utilization of only brief aftercare services. The most dynamic parts of recovery management begin when traditional treatment ends. In the RM model, today's concepts of "discharge" and "aftercare" become anachronistic, as all care is part of the continuity of contact over time between an individual and his or her recovery management team. We know that a significant percentage of clients are precariously balanced between stable recovery and reactivation of addiction in the weeks, months and early years following treatment. What RM models do is place a recovery "coach" in the life of the client at the very time the scales of recovery or re-addiction are being tipped. The service technologies involved in this process include sustained monitoring (including the potential of regular "check-ups"), stage-appropriate recovery education, recovery coaching and problem solving, linkage to relationships within one or more communities of recovery, lapse management, and, when necessary, early re-intervention.

**Expanding the Service Team**

We envision a time when one would pick a recovery management specialist/team like someone with other chronic disorders selects a professional (and, in many cases, a peer system of support) as an ally in the long-term management of the disorder. The size and composition of this recovery management team would be determined by the severity and complexity of the disorder and the unique characteristics and needs of the individual/family. There are three ways that the RM model will change the service team composition. First, it will include the primary care physician as a central member of the recovery management team. One of the first tasks for patients with no primary care physician will be to establish such a relationship. In this way, recovery can be medically monitored within the context of the overall management of global health and integrated within the treatment of collateral health problems. Second, the RM model, by seeking to anchor recovery in the natural environment of the client, involves indigenous institutions and healers within the recovery management team. In Native American communities, tribal elders and traditional healers may become part of this recovery management team. In other ethnic communities, church pastors and elders may be similarly involved. Third, RM models emphasize the value of peer-based recovery support services. These peer mentors may work as volunteers or paid recovery support specialists within a treatment agency or within an independent recovery support agency.

Recovery management seeks to build recovery-focused expertise in two ways. First, it intensifies the recovery education of all staff and builds recovery support functions into all service roles. The focus here is both on the use of evidence based practices in treatment and the structures (pathways), styles, stages and experiences of long-term recovery. Secondly, it re-integrates recovering individuals and family members into the service team as paid or volunteer recovery support specialists (also called recovery coaches/mentors/guides). The goal here is not to replace professional helpers (e.g., the addictions counselor) or replace natural supports in the larger recovery community (e.g., the Twelve Step sponsor), but to expand the range of problem-solving and recovery support resources available to clients/families over the long course of the recovery process. The function of recovery support specialists is not to provide professional treatment services (such would be beyond the boundaries of their education, training and experience), but to: 1) expose people seeking recovery to living proof of the potential for long-term recovery, 2) illustrate the varieties of recovery experience, 3) deliver stage-appropriate recovery education, 4) help remove environmental and personal obstacles to recovery, 5) link clients to the natural resources of the recovery community, and 6) provide a bridge of friendship toward the development of a sobriety-based social network. The intent is

not to professionalize the recovery support specialist role or de-professionalize addiction treatment, but to re-introduce the positive functions that were lost in the modern professionalization of the addiction counselor.

## New Service Evaluation Methodologies

Our traditional method of evaluating addiction treatment is to study the effects of single episodes of intervention, comparing those interventions to either no intervention or different interventions in the months and (at most) few years following the treatment episode. Such methods, while a very reasonable way to assess the treatment of acute disorders where outcomes can be quickly determined, fails to grasp the very essence (the ebb and flow and ever-present nature) of a chronic disorder. The problem with using this evaluation scheme to assess chronic disorders is that what appears to work in the short run (both in terms of health and cost indicators) may not work in the long run, and what appears to not work in the short run may have delayed or cumulative effects over multiple service interventions. Moreover, the current evaluation model focuses predominately on the biomedical realm of addiction (i.e., the elimination of symptoms) without examining many of the other aspects of a person's life that are involved in the process of recovery.

Recovery management models will shift the evaluation focus from short term to long term outcomes, will shift the focus from single service episodes to evaluating combinations and sequences of services and supports (e.g., combining pharmacological adjuncts, psychosocial treatment, sober housing and recovery supports services) (McLellan, 2002), and will include consumers (individuals and families) in the evaluation process at levels that are unprecedented within the history of the field. They will also shift the measure of achievement from the suppression of biomedical symptoms of the individual to the global health of the individual and family. RM evaluation models will measure the extent to which service designs affect the whole person and his or her concurrent or sequential recovery from multiple co-occurring disorders. To that end, evaluation activities will need to assess the extent to which RM models are able to enhance community integration of a broad spectrum of services and support structures.

## Summary

Recovery management wraps the existing acute model of addiction treatment in a resource-rich continuum of pre-treatment, in-treatment and sustained post-treatment recovery support services. Time will tell whether recovery management constitutes the next incremental step in the evolution of addiction treatment or whether it will mark a fundamental shift in how such problems are addressed. Claims of bold new paradigms are often simply a rearrangement of the furniture inside the same conceptual box, while changes viewed as minor innovations can sometimes reflect a major conceptual breakthrough. We suspect that recovery management will turn out to fit this latter pattern masked behind such comments as, "We've always known that," or "We're already doing that."

The Illinois Office of Alcoholism and Substance Abuse has funded a multi-year Behavioral Health Recovery Management project to explore the concept of recovery management and pilot test service and support innovations that flow out of it. Preliminary papers, a recovery resource guide, and clinical guidelines produced by this project can be found at www.bhrm.org. This coming shift from acute treatment to recovery management has many potential benefits but will face many obstacles and pitfalls related to its design and operation. (See White, Boyle, & Loveland, 2002 for a discussion of these.)

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## Behavioral Health Recovery Management: A Statement of Principles

Behavioral Health Recovery Management is a model of intervention for severe mental illness and severe substance use disorders that shifts the focus of care from professional-centered episodes of acute symptom stabilization toward client-directed management of long-term recovery. The following eight principles distinguish the Behavioral Health Recovery Management (BHRM) model.

**1. Recovery Focus:** Full and partial recoveries from severe behavioral health disorders are living realities evidenced in the lives of hundreds of thousands of individuals in communities throughout the world. Where complete and sustained remission is not attainable, individuals can actively manage these conditions in ways that transcend the limitations of these disorders and allow a fulfilled and contributing life. The BHRM model emphasizes recovery processes over disease processes by affirming the hope of such full and partial recoveries and by emphasizing client strengths and resiliencies rather than client deficits. Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioral health disorders.

**2. Client empowerment:** The client, rather than the professional, is at the center of the BHRM model. The goal is the assumption of responsibility by each client for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life. Client empowerment involves not just self-direction of one's own recovery, but opportunities for involvement in the design, delivery, and evaluation of services provided by behavioral health organizations and involvement in shaping public attitudes and public policies regarding behavioral health disorders.

**3. The Destigmatization of Experience:** The BHRM model seeks to "normalize" or otherwise respect a person's experiences with

behavioral health disorders and subsequent services. In this way, the person escapes attacks on self-esteem and self-efficacy that often accompany the stigma of mental illness. Moreover, the public begins to endorse positive images of behavioral health that undermine the prejudice and discrimination that frequently accompanies services.

**4. Evidence-based Interventions:** The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process. The "evidence" under girding such interventions includes scientific studies (randomized clinical trials, clinical field experiments) and inter-disciplinary professional consensus regarding promising approaches, but the ultimate evidence is the fit between the intervention and the client at a particular point in time as judged by the experience and response of the client.

**5. Service Integration:** Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than territorial ownership of the person's problems. The goal is to mesh these historically isolated services into an integrated, recovery-oriented system of care. The BHRM model advocates multi-agency, multidisciplinary service models that can provide less fragmented and more holistic care.

**6. Recovery Partnership:** In the BHRM model, the traditional professional role of "expert" and "treater" progressively shifts to a recovery management partnership with the client. Within this partnership, the professional serves primarily as a "recovery consultant." The service relationship within the BHRM model is marked by continuity of contact in a primary service relationship (with a recovery consultant) over time—a relationship analogous to that between a physician and patient managing any health care problem characterized by chronicity and episodic acuity.

**7. The Ecology of Recovery:** The family (as defined by the client) and community constitute a reservoir of support for long-term recovery from behavioral health disorders. The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioral health disorders. The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the client. One of the major goals of the BHRM model is to create the physical, psychological and social space within which recoveries can flourish in local communities.

**8. Monitoring and Support Emphasis:** The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary re-engagement and early re-intervention. This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders. It also contrasts with mental health programs that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

**9. Continual Evaluation:** Service and support interventions must be matched not only to the unique needs of each client but to the stage-specific needs of each client as these needs evolve through the stages of recovery. In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode. There is also a shift from evaluating single episodes of care to evaluating the effect of particular combinations and sequences of interventions on the course of behavioral health disorders and on recovery careers.



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## Recovery Coaching:
## A Lost Function of Addiction Counseling?

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New service organizations and roles are often birthed from the failure of existing institutions and professions to respond to critical community needs. The modern profession of addiction counseling emerged in the 1970s out of a cultural consensus that existing service institutions and professions had failed to provide a viable solution to alcohol and other drug-related problems. The subsequent professionalization of the role of the addiction counselor set the stage for the development of new roles bearing such titles as recovery coach/mentor/guide and recovery support specialist. This essay explores what the emergence of these roles reveals about the current and future status of addiction counseling.

### Recovery Coaching

Modern research underscores several weaknesses of addiction treatment: low engagement rates of those in need of treatment, high disengagement and extrusion rates following admission to treatment, low rates of participation in post-treatment continuing care activities, and high post-treatment relapse and re-admission rates (White, 2004). These deficiencies are prompting calls to shift addiction treatment from a model of acute intervention to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000). The latter is distinguished by a continuum of pre-treatment, in-treatment, and post-treatment recovery support services. Recovery management models place particular emphasis on sustained monitoring (including recovery checkups) (Dennis, Scott & Funk, 2003), stage-appropriate recovery education, assertive linkage to indigenous communities of recovery, and early re-intervention (White, Boyle & Loveland, 2002).

The recovery management model is reflected in the variety of new services being provided by or linked to addiction treatment agencies under the rubric of "outreach," "case management," "continuing care" and, more recently, "recovery coaching" or "peer-based recovery support services." Such support services are also being delivered within non-traditional community service sites (e.g., churches and new recovery advocacy and recovery support organizations). Several states (e.g., CT, AZ)

are formally integrating recovery support services within their continua of care, while others (e.g., PA) are debating the potential credentialing of these new recovery support specialists.

In service organizations piloting this role, the recovery coach is being described as a:

- motivator and cheerleader (exhibits faith in capacity for change; encourages and celebrates recovery achievements)
- ally and confidant (genuinely cares and listens; can be trusted with confidences)
- truth-teller (provides feedback on recovery progress)
- role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education)
- problem solver (helps resolve personal and environmental obstacles to recovery)
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support)
- advocate (helps individuals and families navigate service systems)
- community organizer (helps develop and expand available recovery support resources)
- lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living)
- friend (provides sober companionship).

Readers of *Counselor* will quickly recognize that these functions overlap those of many existing service roles, including the role of addiction counselor. Recognizing this potential for boundary ambiguity and conflict, agencies experimenting with these new roles insist that the recovery coach is NOT a:

- sponsor (does not perform AA/NA or other mutual aid group service work on "paid time")
- therapist/counselor (does not diagnose or "treat" substance use disorders, and 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).

The recovery coach is a non-professional service role. Persons serving as recovery coaches, rather than being legitimized through traditionally acquired education credentials, draw their legitimacy from *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge is information acquired about addiction recovery through the process of one's one recovery or being with others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others to achieve and sustain recovery. Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise are ideal candidates for the role of recovery coach. The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery to those who have offered sustained living proof of their expertise as a recovery guide (White & Sanders, 2004).

Recovery coaching is at a frontier stage. The role lacks consistent definition and prerequisites across the country. There are potential conflicts with other service roles and voiced concerns about harm that could come to recipients of recovery support services due to incompetence or personal impairment. Orientation, training and supervision protocols are lacking. In short, the role of recovery coach is plagued by the

same issues that faced an emerging profession of addiction counseling thirty-five years ago.

## Recovery Coaching and Addiction Counseling

Advocacy of a new recovery support role suggests that functions to be performed in this new role are not being adequately provided by addiction counselors or by other service roles. What does the recovery coach provide that is not being provided by the addiction counselor? Here are a few possibilities.

*The Wounded Healer Tradition* The recovery coach role provides a venue to re-invite significant numbers of recovered and recovering people back into service roles within the addictions field. The role revives the field's wounded healer tradition—a tradition eroded through the escalation of educational requirements to enter and sustain one's work as an addiction counselor. This quality forces the question: Have important dimensions of the addiction counseling field been lost as a result of the reduced numbers and professional socialization of recovered and recovering people working in the field.

*The Psychology of Optimism* If there is a psychology of recovery coaching, it is a psychology of hope and strength. This raises the question of whether addiction counseling has become too pathology-focused, and, if so, how the field could recapture the infectious hope out of which it was birthed.

*The Ecology of Addiction and Recovery* The target of the recovery coach's interventions are the client's environment as well as the client's thoughts, feelings and behaviors. This emphasis on nesting recovery within the client's natural environment raises the question of whether the function of addiction counseling has become too imbedded within institutional environments and too detached from community conditions that either support or undermine recovery.

*Knowledge of Cultures of Recovery* The recovery coach role is designed to shift the connection between treatment centers and indigenous cultures of recovery from one of passive referral (e.g., encouragement to attend mutual aid groups) to assertive linkage (guided exposure to multiple local communities of recovery). This raises the question: Is today's more educated addiction counselor less knowledgeable about long-term recovery and indigenous communities of recovery than the "paraprofessional" counselor of the early 1970s?

*Decreasing Power Discrepancy* The recovery coach role offers a relationship that is less hierarchical and less commercialized. This raises the question of whether the therapeutic alliance of addiction counseling has been weakened by the over-professionalization and over-commercialization of the role of addiction counselor. Have we squeezed the natural juices out of the addiction counselor role, leaving it a more technically proficient but less emotionally authentic shadow of its original?

*Continuity of Contact in a Primary Service Relationship* The recovery coach role offers the person seeking recovery what the addiction counselor cannot: a sustained recovery alliance. As addiction treatment and all levels of care within it have become ever briefer, the question can be raised whether the counselor-client relationship has become so brief that today's counselor has little ability to guide the transition from recovery initiation to recovery maintenance.

## Closing Reflections

In some ways we have come full circle. The role of recovery coach contains many essential dimensions of the role of addiction counselor—dimensions that some feel have been lost or diluted. As addiction counseling gets further integrated into (or colonized by) more powerful fields, the recovery coach may become the torch bearer of critical aspects of the specialty knowledge and skill that marked the birth of addiction counseling. What is clear at this moment is that recovery coaches are seeking to meet needs not being addressed within the current rubric of addiction counseling. How these needs are addressed

will exert a profound effect on the future of addiction treatment as a system of care and the future of addiction counseling as a profession. If some immeasurable qualities of addiction counseling have been lost, it is time me mourn that loss and either recapture those lost functions or celebrate the entry of these new recovery support roles within the field of addiction treatment.

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# Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities

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Abstract

*Communities of color have been ill-served by acute care models of treating severe alcohol and other drug (AOD) problems that define the source of these problems in idiopathic (biopsychological) terms and promote their resolution via crisis-elicited episodes of brief, individual interventions. This article explores how approaches that shift the model of intervention from acute care (AC) of individuals to a sustained recovery management (RM) partnership with individuals, families and communities may be particularly viable for historically disempowered peoples. The advantages of the RM model for communities of color include: a broadened perspective on the etiological roots of AOD problems (including historical/cultural trauma); a focus on building vibrant cultures of recovery within which individual recoveries can be anchored and nourished; a proactive, hope-based approach to recovery engagement; the inclusion of indigenous healers and institutions with the RM team; an expanded menu of recovery support services; culturally-grounded catalytic metaphors and rituals; and a culturally- nuanced approach to research and evaluation.*

**Key Words**: Addiction, chronic disease, recovery management, African American, Native American

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## Introduction

Addiction has been characterized as a "chronic, progressive disease" for more than 200 years (White, 2000a), but interventions into severe alcohol and other drug (AOD) problems continue to be based on serial episodes of self-encapsulated, acute intervention (O'Brien and McLellan, 1996; Kaplan, 1997). Recent research has confirmed the chronic nature of severe AOD problems (Hser, Anglin, Grella, Longshore, & Pendergast, 1997; Scott, Foss, & Dennis, 2005) and compared such problems to other chronic health disorders (e.g., type 2 diabetes mellitus, hypertension and asthma) in terms of their etiological complexity, variability of course, and recovery and relapse rates (McLellan, Lewis, O'Brien, & Kleber, 2000). Calls for shifting addiction treatment from an acute care (AC) model to a model of sustained recovery management (RM) are increasing (White, Boyle, & Loveland, 2002, 2003; Compton, Glantz, & Delaney, 2003; Edwards, Davis, and Savva, 2003), and components of such models are currently being evaluated with adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002) and adults (Dennis, Scott & Funk, 2003; Scott, Foss & Dennis, 2005b). The emerging model of recovery management has been defined as:

> *…the stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a time-sustained, recovery-focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe behavioral health disorders until full remission has been achieved or until recovery maintenance can be self-managed by the individual and his or her family* (White, Boyle, Loveland & Corrigan, 2003).

This article contrasts the application of AC and RM models of intervention into severe AOD problems within communities of color. We will focus specifically on those American Indian/Alaskan Native, African American,

Hispanic/Latino and Asian and Pacific Islander communities whose members present unique obstacles and resources as they enter publicly funded treatment for severe AOD problems. Our contrast of AC and RM models is drawn from the pioneering work of McLellan, Lewis, O'Brien and Kleber (2000) and from descriptions of the changes in clinical practice within the RM model (White, Boyle & Loveland, 2002, 2003; White, 2005; Scott, White & Dennis, 2007). We argue that historically disempowered persons, and, in particular, communities of color, have been ill-served by acute, biomedical models of intervention into AOD problems, and that models of recovery management hold great promise in providing more effective solutions to AOD problems within these communities.

Great care must be taken that discussions of the needs of communities of color do not inadvertently contribute to stereotypes about these communities. To determine whether RM models of intervention hold greater promise than AC models, we will need to explore those characteristics of communities of color that have relevance to the viability of these models. Given the enormous differences within and between ethnic communities and the changes in these communities over time, we would ask readers to keep all observations, ideas and strategies set forth in this article on probation pending their validation within particular communities and with particular individuals and families. "People of color" and "communities of color" do not constitute a monolithic group to which a single explanatory or intervention model can be indiscriminately applied. Testing components of the RM model will need to be conducted in all ethnic communities and across multiple subpopulations within those communities. We hope this introductory paper will stand as an invitation for such sustained exploration.

We will begin by contrasting how AC and RM models conceptualize the sources and solutions to AOD problems and then explore the RM model's emphasis on proactive engagement, the use of indigenous healers and institutions, catalytic rituals and metaphors, new technologies of monitoring and recovery support, a sustained recovery management partnership, and the need for culturally-nuanced approaches to research and evaluation.

## AC and RM Models: The Source of AOD Problems

> *American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This*

*phenomenon,…contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism and other social problems among American Indians.* --Brave Heart and DeBruyn, 1998

*When people are taught to hate themselves, they will do bad things to themselves*. --Sanders, 1993.

Acute care (AC) models of intervention have assumed that the sources and solutions to AOD problems reside within the individual, and that brief interventions to alter an individual's physical, cognitive and emotional vulnerabilities can produce a permanent resolution of these problems. RM models posits that AOD problems spring from multiple, interacting etiologies; unfold (suddenly or progressively) in highly variable patterns; ebb (remission) and flow (relapse) in intensity over time; and are resolved at different levels (from full to partial) via multiple long-term pathways of recovery. People of color may be at risk for AOD problems, but these risk factors differ between and within ethnic groups (Matsuyoshi, 2001).

The RM model suggests that historical, political, economic, and socio-cultural circumstances can also serve as etiological agents in the rise of AOD problems. Client discussions about cultural pain (e.g., slavery, the loss of land, attempted extermination, epidemic diseases, the purposeful break-up of tribes and families, the loss of families and culture via immigration or forced deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism and discrimination) are viewed, not as defocusing or acting out, but as a medium of a consciousness raising and catharsis that can open doorways to personal/community healing and transformation (Green, 1995). This approach is much more congruent with beliefs within communities of color that their AOD problems result as much from historical trauma[1], economic and political disempowerment, and cultural demoralization as from biological vulnerability (Manson, 1996; Brave Heart & DeBruyn, 1998; Brave Heart, 2003). Culturally-nuanced models of RM reflect an understanding of the effects of intergenerational trauma (grief, rage, self-hatred, self-medication) upon whole communities. Positing multiple pathways of long-term recovery also opens up the potential for culturally prescribed

[1] Maria Yellow Horse Brave Heart (2003) has defined historical trauma as "cumulative emotional and psychological wounding over the lifespan and generations, emanating from massive group trauma experiences."

frameworks of AOD problem resolution (abstinence-based religious and cultural revitalization movements, e.g., the Nation of Islam) as well as cultural adaptations of existing recovery support structures (e.g., the "Indianization" of Alcoholics Anonymous and the adaptation of A.A. within Hispanic/Latino communities) (Womak, 1996; Hoffman, 1994).

RM models assume that severe AOD problems constitute complex, chronic disorders that require sustained individual, family, community and cultural interventions for their long-term resolution. In this view, treating severe and persistent AOD problems via AC models of intervention is as ineffective as treating a bacterial infection with half the effective dose of antibiotics. Such treatment may temporarily suppress symptoms, but often results in the subsequent return of the problem in a more virulent and treatment-resistant form. In the RM model, the treatment of severe and persistent AOD problems is delivered within a sustained recovery management partnership that provides on-going recovery support and consultation and anchors the recovery process in indigenous supports within the client's natural environment.

Chronic disorders such as diabetes and heart disease take an undue toll on communities of color, but substantial efforts are underway within communities of color for the prevention, early intervention, and sustained management of such chronic health problems. As communities of color learn more about the nature and treatment of chronic primary health disorders, that knowledge base can be extended to severe AOD problems. There is already some recognition of addiction as a chronic disorder via people of color sustaining hope for a family member or friend's recovery, long after the rest of the world has lost such hope. That capacity for patience, compassion and forgiveness is not a sign of pathology (codependency), but an unheralded resource of hope and support within communities of color that the RM model seeks to build upon.

The acute care model rests on the assumption that AOD problems are self-contained and that individuals have the internal and external resources to sustain recovery and assume full social functioning following detoxification and brief treatment. It assumes a foundation of pre-morbid skills and social functioning. This rehabilitation model promises the client that he or she will regain prior levels of functioning and status lost via the accelerating severity of AOD problems. This model is poorly suited for individuals who have not achieved such prior levels of successful functioning and who have few if any significant supports for recovery within their families and social networks. The model is particularly unsuited for those poor communities of color whose members present

with high AOD problem severity, numerous co-occurring problems, and low "recovery capital" (internal and external resources that help to initiate and maintain recovery) (Granfield and Cloud, 1999).

In contrast, the RM model assumes that clients have widely varying degrees of problem severity and recovery capital and that the degree and duration of need for recovery support services requires differential allocation of services across these levels of functioning. Where levels of care within traditional treatment are dictated primarily by problem severity, RM models set service intensities and duration based on the unique interaction of problem severity and recovery capital. For those with little recovery capital, RM provides a framework for sustained habilitation.

**The RM Solution: Personal, Family and Community Renewal**

> *Ultimately, it is the community that cures....To cure the wounded, one need only return them to their community or construct a new one.*
> --Philip Rieff, 1987

> *Community healing along with individual and family healing are necessary to thoroughly address historical unresolved grief and its present manifestations.* --Brave Heart and DeBruyn, 1998

The unit of service within the AC model is the individual with an AOD problem. Professional interventions are designed to lower the biological vulnerability and alter the beliefs and behaviors thought to sustain addiction. When the AC model fails to resolve AOD problems, the root of that failure is viewed as residing inside the individual. The professional response, in practice if not in theory, is to prescribe additional repetitions of the failed intervention. Of people admitted to publicly funded addiction treatment in the U.S., 64% already have one or more prior admission, including 22% with 3-4 prior admissions and19% with 5 or more prior admissions (OAS, 2005). An aggressive system of managed behavioral health care has lowered the intensity and duration of these treatment episodes, further lessening the viability of addiction treatment for persons within communities of color who present with the highest problem severity, complexity and chronicity.

Within the RM model, individuals with AOD problems are viewed as being nested within a complex web of family, social and cultural relationships. Each level of this social ecosystem can contribute to the development of, help resolve, or sabotage efforts to resolve these problems. As a result, it is the whole ecosystem rather than the individual that is the target of the RM intervention. RM moves beyond the clinical skills of assessment, diagnosis and treatment of individuals to encompass the skills of family reconstruction, community resources development, and nation-building (see the work of White Bison, Inc. for examples of the latter). RM in communities of color is premised on the belief that connection to community is an essential dimension of personal healing.

In the AC model, the family is a stimulus for help-seeking, a source of emotional and financial support for treatment retention, and a target for brief education and referral to peer-support (e.g., Al-Anon). The assumption is that whatever wounds the family suffered through the addiction experience will naturally and quickly reverse themselves following the addicted family member's recovery initiation. In contrast, the RM model is based on the following six assumptions about the impact of addiction on the family and the family's role in the recovery process.

1) Addiction is but one wound families of color have suffered via the intergenerational transmission of historical trauma (e.g., the forced breakup of family units in slavery, the Indian boarding schools and their prolonged aftermath, traumatic separation via immigration) and that the family unit itself needs a sustained process of recovery from these wounds (Brave Heart and DeBruyn, 1998).

2) The addiction-related transformation of family roles, relationships, rules and rituals are deeply imbedded within family members, and habitual patterns of family interaction will not spontaneously remit with recovery initiation.

3) There are developmental stages of family recovery that entail personal healing, a realignment of family subsystems (adult intimate relationship, parent-child relationships, and sibling relationships), and the families relationship with the outside environment—tasks that consume the first 3-5 years of stable recovery (See Brown and Lewis, 2002).

4) Families who do not have sufficient supports to make these difficult transitions are at high risk for disintegration—in spite of their having remained intact through years of addiction (Brown and Lewis, 2002).

5) Sustained recovery monitoring and support for family members is as crucial as it is for the individual recovering from severe AOD problems.
6) RM services for families need to be refined based on the unique family and kinship patterns that exist within particular ethnic communities.

The importance of community in understanding AOD problems within communities of color is perhaps most evident within the rising Wellbriety movement in Indian Country. A central idea within this movement is the "Healing Forest" metaphor developed by Don Coyhis (1999). In Coyhis' work, the AC model of treatment is analogous to removing a sick tree from diseased soil, nursing it back to health in well-fertilized and well-watered soil and then returning it to the diseased soil from which it came. Coyhis suggests that we would need fewer tree hospitals if we treated the trees AND the soil in which the trees suffer or thrive. He calls for the creation of a "healing forest" to nurture sobriety and wellness. This broader vision of creating healthy communities that resist AOD problems and within which recovery can thrive is pervasive in communities of color but is markedly absent within the professional field of addiction treatment.

In communities of color, the individual, the family and the community are inseparable. To wound one is to wound the other; to heal one is to heal all (Red Road to Wellbriety, 2002). When interviewed about how the Shuswap tribe in Alkali Lake, British Columbia successfully reduced its alcoholism rate from nearly 100% to less than 5%, Chief Andy Chelsea declared simply, "the community is the treatment center" (quoted in Abbot, 1998; See also Chelsea & Chelsea, 1985 & Taylor, 1987). The most effective and enduring solutions to AOD problems among people of color are ones that emerge from within the very heart of communities of color. The RM model seeks to tap this vein of resistance and resilience by recognizing and enhancing the recovery support capacities of families, kinship networks, indigenous institutions (e.g., mutual aid groups, churches, clans) and whole communities and tribes.

**Proactive Engagement**

*My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.* —Outreach Worker (Quoted in White, Woll, & Webber, 2003)

The AC model of intervention is essentially crisis-oriented. It relies on internal pain or external coercion to bring individuals to treatment, and places the responsibility for motivation for change squarely and solely on the individual. It assumes that people move from addiction to recovery when the pain of the former state reaches a point of critical mass. The AC model is also characterized by a high threshold of engagement (extensive admission criteria and procedures), high rates of client disengagement (terminating services against staff advice) and high rates of client extrusion ("administrative discharge" for non-compliance) (White Scott, Dennis & Boyle, 2005).

In contrast, the RM model is characterized by assertive models of community outreach, pre-treatment recovery support services, and a proactive approach to the resolution of personal and environmental obstacles to recovery. Motivation for recovery is not assumed to be static—a dichotomous (you have it or you don't) entity. It is assumed that such motivation waxes and wanes and that active recovery coaching can help the client transcend periods of heightened ambivalence, diminished confidence and recovery-induced anxiety. One of the earliest examples of such proactive outreach was the work of the East Harlem Protestant Parish among New York City's Puerto Rican heroin addicts in the 1950s. This faith-based program recruited addicts from the streets and enmeshed them within pro-recovery social clubs and a larger religious community (White, 1998).

The proactive engagement of the RM model is particularly suited for individuals whose personal/cultural experiences have engendered an exceptionally high physical and emotional tolerance for pain and for those who have never known anyone in recovery. Proactive engagement is also important for people of color who:

- lack the knowledge, skills and financial resources required to navigate complex health and human service systems;
- fear bringing shame to their families (losing "face") by breaking prohibitions on disclosing personal problems outside the family or kinship network--shame dramatically enhanced for women,
- have had negative experiences within or distrust formal service systems,
- bring special obstacles to accessing services (e.g., language barriers, illegal status), and
- who possess beliefs about illness and health that conflict with the explanatory metaphors of mainstream service systems.

The RM model of engagement is particularly well suited for people of color whose resistance to treatment flows from the inertia of hopelessness. RM models place great emphasis on working within the pre-action stages of change and the long-term maintenance stages of change (Prochaska, DiClemente, & Norcross, 1992).

Of all the obstacles that proactive engagement is designed to address, perhaps the most difficult in both AC and RM models is the issue of language. Key informants from many ethnic communities emphasized the need for more bilingual professionals and service volunteers. This language barrier will need to be overcome if RM models are to fulfill their potential within ethnic communities. The outreach and assertive continuing care functions, in particular, will require a high level of cultural and linguistic fluency. The RM emphasis on building service capacity within communities offers some hope for expanding such competence.

While this assertive model of engaging and supporting individuals through the stages of recovery is well-suited to the obstacles and complex needs presented by many people of color, great care will need to be taken with this aspect of the RM model. The values of benevolence, generosity and service co-exist with the value of noninterference in the affairs of others within communities of color. The implementation of RM models in communities of color will require considerable care to avoid violating this latter value. The key will be to use RM's assertive approach to engagement and post-treatment monitoring and support, but to do so only with the continuing consent of the community, family and individual client.

Another dimension of the RM model (emerging from its view of multiple pathways of recovery) is its respect for the power and legitimacy of transformative change (change that is unplanned, positive and permanent) as a medium of recovery initiation (Miller and C'de Baca, 2001). Non-ordinary experiences (e.g., dreams, visions, climactic conversions) have long marked a pathway of addiction recovery for people of color, particularly among those who have led religious and cultural revitalization movements (e.g., Handsome Lake, Malcolm X). In contrast to the conversion style of induction, recovery may also be marked by a reaffirmation and deepening of existing religious/spiritual beliefs and practices, as Morjaria and Orford (2002) found in their study of South Asian American men (see also Manik, et al, 1997).

Where traditional AC models of treatment tend to discount the power and durability of religious experiences and the role of religious institutions as viable

sobriety-based support structures, the RM model celebrates the legitimacy of these experiences and support institutions. Sustained sobriety can be a byproduct of religious and cultural affiliation and heightened ethnic identity, whether this occurs within the Nation of Islam, the Indian Shaker Church or a Buddhist or Hindu Temple. Such recoveries involve not just a redefinition of personal identity, but a redefinition of oneself as an *Indian, African American, Latino* or *Asian* person. For example, Spicer's studies of recovery in Native American communities found that recovery initiation was associated with heightened Indian identity and the incompatibility between drinking and emerging beliefs about how Indian people should conduct their lives (Spicer, 2001). This recognition of the power of culturally mediated transformative change provides a foundation of respect upon which RM-based organizations can collaborate with religious and cultural revitalization movements within communities of color.

**Indigenous Healers/Institutions and the Recovery Management Team**

> *Many individuals maintain sobriety only after they resume or begin regular involvement in traditional spiritual practices*. --Brave Heart and DeBruyn, 1998
>
> *The persistence and revival of indigenous Amerindian healing is due not to a lack of modern treatment services, but to a need for culture-congenial and holistic therapeutic approaches*. –Jilek, 1978

AC treatment interventions are delivered by an interdisciplinary team of physicians, nurses, psychologists, social workers, and addiction counselors. The RM model, recognizing other dimensions of AOD problems (e.g., economic, political, cultural, spiritual, religious), broadens the recovery management team to include indigenous community institutions and healers. People of color utilize cultural healing therapies as alternatives or adjuncts to mainstream medicine and psychiatry, with the majority not reporting use of these alternative therapies to their mainstream service providers (Keegan, 1996).

Studies of the course of alcohol problems among American Indians have found remission/recovery rates as high as 60%, with few such recoveries attributable to formal alcoholism treatment (Spicer, 2001). American Indians have a long history of abstinence-based religious and cultural revitalization movements, indigenous healers as mediums of alcoholism recovery, and the use

of Native medicines and ceremonies as adjunctive supports for recovery (White, 2000b; Coyhis & White, 2006). Growing awareness of this history has spurred calls for culture-congenial therapeutic approaches via an integration of Western treatment methods and traditional Native American healing practices (Jilek, 1974; Weibel-Orlando, 1987; Westermeyer, 1996). There is similar evidence for indigenous recovery frameworks in the Hispanic/Latino (Thomas, 1967; Singer and Borrero, 1984; Núñez Molina, 2001), Asian (Das, 1987; Yamashiro, & Matsuoka, 1997) and African-American communities (Leong, Wagner, & Tata, 1995). These indigenous recovery frameworks place great emphasis on the healing power of *regalos*—cultural values and ceremonies. The RM model is open to the inclusion of such institutions and their representatives within the recovery management team. In the RM model, the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist may each play a role within the RM team.

A recent evaluation of gender-specific addiction treatment programs in Illinois found that a significant number of recovering and recovered African American women are using the Black Church as their primary sobriety-based support structure, but most do so only months after initiating recovery and addressing issues of shame related to their addiction (White, Woll & Webber, 2003). Similar documentation exists on the use of religious frameworks of addiction recovery in other communities of color (Núñez Molina, 2001; Coyhis & White, 2006). This raises an interesting point about the differences between how individuals initiate recovery versus how they sustain that recovery over time. More specifically, it suggests that some clients of color may use one institution to initiate recovery (e.g., professionally-directed treatment, Alcoholics Anonymous or Narcotics Anonymous), but use culturally indigenous institutions to sustain recovery (e.g., the Black Church). Failure to sustain recovery could thus be viewed not as a need for more recovery initiation services (the AC treatment model), but a need to find a cultural pathway of long-term recovery maintenance (the RM model).

The RM model assembles professional and indigenous service teams to meet the unique recovery support needs of each client and family. The rationales for the use of such non-traditional teams are to expand the recovery support services available to individual clients and to decrease the number of people needing professional services by expanding natural recovery supports within the larger community. The inclusion of indigenous healers and recovery support

institutions rests on a simple assumption: the natural community is an oasis of human and spiritual resources that can be tapped to resolve personal and family problems (McKnight, 1995). In the RM model, the centerpiece of recovery is not the treatment institution, but the client and his or her relationship to this larger community.

The inclusion of non-traditional roles within the RM service team raises the question of credibility and credentialing of service providers within communities of color. Credibility bestowed from the dominant culture has value within communities of color only when the individual with such credentials is further vetted inside the community. This is typified by the concepts of *respeto*, *personalismo*, and *dignidad*, and *confianza* within Hispanic/Latino communities--concepts that dictate respect based on personhood rather than financial or occupational status (Soriana, 1995). Credibility in communities of color is more likely to be bestowed upon those with nonjudgmental attitudes, knowledge of the culture and demonstrated resourcefulness and effectiveness (Sue & Sue, 1999).

Credibility as a healer inside communities of color requires two things: *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. 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 living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships and performance within the community. RM models capitalize on such experiential expertise by recruiting indigenous healers as legitimate members of recovery management teams, e.g., outreach workers, recovery coaches, and culturally-grounded therapists/nurses/physicians.

RM also turns those seeking help into sources of support for others via their involvement in mutual support groups, peer-based service models and recovery advocacy organizations. Within communities of color, there is a long

history of the concept of "wounded healer" (the idea that surviving a life-threatening illness or experience bestows knowledge and an obligation to help others facing this illness or experience), and a tradition of helpers credentialed by "calling" (White, 2000b). By transforming the process of recovery from an interaction between a professional and a patient to reciprocal support among members of a community of recovering and recovered people, RM taps this wounded healer tradition and utilizes what has been christened the "helper-therapy principle" (the therapeutic effects of helping others)(Reissman, 1990, 1965). Converting service recipients into service dispensers exponentially expands indigenous recovery resources within communities of color. Reaching out to the suffering alcoholic/addict has been espoused by leaders of American recovery communities, from the Washingtonian mantra, "You've been saved, now save another" (White, 1998) to what Malcolm X referred to as "fishing for the dead" (Myers, 1993, p. 82). With its emphasis on transforming people who have been part of the problem into part of the solution, RM creates a cadre of people whose living example and recovery advocacy activities can help neutralize the particularly intense stigma that has long been attached to addiction in communities of color.

**People of Color and the Criminal Justice and Child Welfare Systems**

People of color, particularly African Americans, are over-represented within America's criminal justice and child welfare systems. Constituting only 12.1% of the U.S. population (U.S. Census Bureau, 2000) and 15% of illicit drug consumers (SAMHSA, 1998), African Americans constitute 56.7% of those currently in state prison on drug offenses (Harrison & Beck, 2003). Studies have also shown that race plays an important role in involvement in child protection services. Although rates of drug use during pregnancy are nearly identical for African American and White women, African American women are ten times more likely to be reported to child protection authorities for prenatal drug exposure (Neuspiel, 1996; Chasnoff, Landress, & Barret, 1990). Any intervention into alcohol and other drug problems in communities of color must recognize the dominant role of the criminal justice and child welfare systems as treatment referral sources.

The AC model of intervention is strongly linked to these systems and that is itself a problem. People of color with high problem severity and complexity continue to be routinely placed in brief interventions that have little chance of

success and then are punished (via incarceration or loss of custody of children) on the grounds that "they had their chance" when those likely outcomes occur. The financially motivated collaboration of the treatment system in this process is altering the perception of treatment institutions from institutions of service and care to institutions of coercion and control. Masked behind euphemisms such as "treatment works" is the story of how addiction treatment programs have become an extension of the criminal justice and child protection systems within communities of color. We would argue that it is not enough to deflect people of color into treatment as an alternative to incarceration or family disintegration. The treatment received must be designed in such a way as to offer a realistic chance of success. Punishing people with high problem severity for failing to achieve sustained abstinence following treatment within an AC model is part of a long history of "blaming the victim" within communities of color.

It remains to be seen whether RM models will offer a more viable option for people of color involved in the criminal justice and child welfare systems, but RM models do have several characteristics that make success more likely. First, the longer duration of service contact in the RM model is more realistic and constitutes more of a real "chance" than treatment based on the AC model. The RM emphasis on engagement and sustained monitoring and support is very congruent with such criminal justice initiatives as intensive probation, drug courts and sentencing circles. It is also congruent with the gender-specific addiction treatment models emerging within the child welfare system (White, Woll, and Webber, 2003). More effective systems of intervention and support could decrease the number of people entering, and widen the doorways of exit from, the criminal justice and child protection systems.

## Expanded Menu of Services and Catalytic Metaphors

> *Metaphors are culturally-grounded figures of speech that in their subtlety, complexity and power strike deep emotional cords that ignite processes of personal transformation.* --White & Chaney, 1993

> *…transformations of the self and its relationship to core symbols in a particular cultural system of meaning appear to lie at the heart of how people are restored to wholeness following their problematic involvements with alcohol.* --Spicer, 2001

The AC model of addiction treatment is based on the development of "programs" (a prescribed combination and sequence of therapeutic activities) that clients experience with minimal variation. Program activities and protocol focus on detoxification, problem stabilization and recovery initiation. RM models, by placing equal or greater emphasis on pre-treatment engagement and post-treatment recovery maintenance, expand the service menu considerably. The RM service menu is based on three premises:

1) People with AOD problems represent multiple clinical subpopulations with diverse needs: the effectiveness of treatment and support services varies considerably across clinical subpopulations and individuals within these subgroups.
2) There are developmental stages of long-term recovery: the same individual may need different treatment and support services at different stages of his or her addiction and recovery careers.
3) There are qualitative differences between AOD problems and the processes used in their resolution within communities of color.

RM replaces the treatment "program" with a large menu of service and support activities that are uniquely combined and supplemented to meet the stage-dependent needs of people in recovery. In this model, the service menu is constructed using frameworks of healing drawn first from the client's own cultural background, e.g., the use of specialized therapies such as the Japanese psychotherapeutic approach known as *Naikan* where the patient is sequestered for self-reflection on his or her character and relationships under the guidance of periodic visits from the therapist (*sinsei*) (Das, 1987). RM seeks to initiate and sustain recovery within the framework of cultural values using methods that markedly differ from client to client (Flores, 1985-86). The shift toward a multicultural menu of values and service activities requires a high degree of individualization and knowledge of the personal, intracultural and transcultural processes of long-term recovery.

RM proponents are also interested in the kinds of words, ideas, metaphors, and rituals that initiate and strengthen recovery, mark the shift from one stage of recovery to the next, and sustain recovery over a prolonged period of time. This interest is congruent with the belief in the power of words (speeches, sermons and stories) and healing ceremonies within communities of color. The following

assumptions describe the potential role of words, ideas, metaphors and rituals in the addiction recovery process.

1) Words, ideas, metaphors and rituals can exert an enslaving or liberating effect on one's relationships with alcohol and other drugs (White and Chaney, 1993; White, 1996).
2) Words, ideas, metaphors and rituals that serve as a catalyst for change in one person or cultural group may have no such power with other persons or cultural groups. There are specific ethnic/cultural worldviews and the elements of these worldviews constitute the raw materials from which pathways of resilience to and recovery for AOD problems must be constructed (Taylor, 1992).
3) Catalytic metaphors[2] evolve and recycle within cultures over time. Their use as agents of transformation rests on their contemporary power; they must resonate within the present cultural and personal experience of the individual seeking recovery.
4) The growing phenomenon of biculturalism suggests that individuals may be able to combine or sequence metaphors from two or more cultures to initiate recovery or shift from one stage of recovery to the next.
5) Addiction treatment programs serving heterogeneous populations must provide a diverse menu of organizing words, ideas, metaphors and rituals to widen the doorways of entry into recovery and support culturally-mediated stages of long-term recovery (White, 1996).

The following observations reflect the ways in which words, ideas, metaphors and rituals have been used by historically disempowered peoples to initiate and sustain recovery from addiction.

1) During the peak period of contact and colonization, people of color are prohibited from drinking or provided only controlled opportunities for drinking (e.g., Slave Code prohibitions on drinking, Federal prohibition of the sale of alcohol to American Indians) and are targeted via drug prohibition laws (e.g., anti-opium ordinances aimed at Chinese immigrants, anti-cocaine laws aimed at African Americans, anti-peyote

[2] 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.

laws aimed at American Indians, and anti-marihuana laws aimed at Mexican immigrants) (Musto, 1973; Helmer, 1975; Morgan, 1983).

2) Patterns of psychoactive drug use and their effects upon people of color are exaggerated or fabricated as part of a racial mythology that justifies colonization and cultural domination (e.g., Native American "firewater myths") (Coyhis & White, 2006; Morgan, 1983)
3) People of color, in their early struggles for liberation, use the consumption of alcohol and other drugs to cope with feelings of hopeless and to deal with historical trauma.
4) Political and religious leaders within communities of color subsequently link AOD use to historical oppression, portray alcohol and other drugs as weapons of continued colonization and domination of their communities (Tabor, 1970; Herd, 1985), and portray sobriety as an act of resistance and liberation (Douglas, 1855; Cheagle, 1969).
5) Recovery mutual aid movements arising out of historically disempowered people emphasize metaphors of resistance, emancipation, and power, e.g., "I have a problem that once had me" (Kirkpatrick, 1986), "I will take control of my life" (Williams & Laird, 1992).
6) Heightened consciousness of racial history and identity can be a pathway of entry into recovery, or it can be part of a process of discovery in the later stages of recovery (Green, 1995).

The RM model embraces and works within these alternative frameworks of recovery. The viability of a particular metaphor for understanding AOD problems and how they can be resolved varies widely between cultures and varies degree of acculturation. The question is not: Which explanatory metaphor is true? The question is: Which organizing metaphor, by explaining things that are otherwise inexplicable, serves as a catalyst for personal, family and community healing. There are many people of color who have found recovery through mainstream treatment and recovery support organizations (e.g., AA/NA), but there are also many people of color who have recovered from addictions who do not portray themselves as having suffered from the *disease* of *alcoholism/addiction* nor portray themselves today as *alcoholics* or *addicts* in *recovery*. They have found alternative rationales for sobriety and different metaphors to explain who they once were and who they are today (Spicer, 2001).

The goal of RM is not to impose an organizing metaphor for recovery, but to work within whatever metaphors individuals and families find most personally and culturally meaningful.

**Sustained Monitoring and Support**

> *Chronic diseases require chronic cures.* --Kain, 1828
>
> *If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients.* --McLellan, 2002

Communities of color have become distrustful of promised quick fixes because so many of those promises have been betrayed. Professionals come and go; programs come and go; agencies come and go. Arguments over whether addiction treatment should consist of five sessions or 25 sessions, five days or 30 days, cognitive or family therapy are all arguments inside the acute care model of admission, treatment, and discharge. The inherent brevity of acute interventions into complex, chronic problems is often experienced as superficial pacification, professional disinterest, exploitation and abandonment. People of color, who tend to enter addiction treatment at later stages of problem severity and a greater number of co-occurring problems (Bell, 2002), are ill-served by service models whose low intensity and short duration offer little opportunity for success. At a practical level, the acute model provides few options: regular readmission for detoxification and respite, demoralization and a cessation of treatment-seeking, or a search for recovery maintenance outside the realm of professionally-directed treatment.

Communities of color need stable recovery support institutions that can move beyond brief experiments in recovery initiation toward prolonged recovery maintenance. It is this very need that has contributed to the dramatic growth of AA, NA and recovery-focused ministries in communities of color. For those who need sustained professional support, RM provides a culturally viable model of addiction treatment that replaces crisis intervention with a much longer, but lower-intensity, continuum of pre-treatment, in-treatment, and post-treatment recovery support services.

## A Recovery Management Partnership

> *Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work.* --Albert Schweitzer**,** From *Reverence for Life*, 1993

The service relationship within acute care approaches to addiction treatment is based on an "expert" model of problem intervention. In this model, the service professional is assumed to have considerable knowledge, resources and power while the service recipient is assumed to suffer from one or more problems that he or she does not understand and cannot resolve. The role of the expert is to diagnose the problem, treat the problem and briefly educate the client regarding his or her continued self-care responsibilities related to the problem. Failure to resolve the problem is usually attributed to the lack of "patient compliance" with the expert's recommendations. The service relationship within the AC model of intervention, whether in the form of an emergency room visit for a broken bone or brief addiction treatment, is hierarchical, transient and commercialized. It reflects what Eisler (1987) has christened the "dominator model" of interpersonal relationships.

The historical victimization and abandonment of people of color have left a legacy of mistrust and caution when approaching relationships characterized by high discrepancies of power and brevity of contact. Given this legacy, developing trust in service relationships with people of color requires testing and time, and time is the one commodity the AC model, by definition, cannot provide.

RM models provide an alterative by providing continuity of contact in a sustained service relationship, shifting the nature of that relationship from one based on hierarchy to one based on a recovery management partnership, and incorporating support relationships (e.g., with volunteer recovery coaches) that are natural (reciprocal) and non-commercialized. In the RM partnership, it is assumed that strengths and weaknesses exist on both sides of the relationship, and that there is no universally effective professional intervention for severe AOD problems. Where the expert model is based on a teacher-student relationship, the partnership model assumes that learning will be mutual within the service relationship. A number of recovery initiation and maintenance strategies are co-developed and tried within the partnership relationship until the most effective strategy is found. Continuity of contact over time is crucial to the

RM model, making the issue of high staff turnover a potential Achilles heel of the RM model.

A second Achilles heel of the RM partnership model is the danger that it could evolve into patterns of prolonged dependency that already exist in the AC model. Cultivating professional dependence and creating "system-sophisticated" clients that know how to "do treatment" and manipulate resources to sustain active addiction is counterproductive and constitutes another form of colonization (using such clients as a cash crop to run the institutional economies of service industries and sustain the careers of service professionals). The goal of RM is a habilitation process that replaces dependency on formal service systems with interdependency within a larger social and cultural community. The essential principle is that professionally-directed services are the last, not the first, line of response to AOD problems and that professionally-delivered RM services should provide only what cannot be provided within the larger network of family and indigenous community supports.

RM models may also force agencies to redefine their institutional identities from one of a service-oriented business to a member of multiple communities of recovery—memberships that bring their own demands for accountability related to competence, consistency and continuity of access. Providing continuity of support and defining oneself in terms of personal and institutional membership in local communities of recovery are much more congruent with the natural patterns of helping within communities of color than are the "expert" or "business" models of delivering acute addiction treatment services.

## Culturally-nuanced Research and Evaluation

> *Indian communities recognize all too well that the research process can be intrusive and the results invidious, divisive, and scandalous*. --Beauvais and Trimble, 1992

> *…attempts to evaluate service program must have a dual acceptability; that is, they must be acceptable to the rigors of scientific exploration as well as the African-American ethos and worldview.* –Butler, 1992

Both the acute model and recovery management model aspire to be evidence-based, but the former is based primarily on short-term scientific studies

of the efficacy (what works under ideal conditions) and effectiveness (what works under real conditions) of a single episode of brief intervention (McLellan, 2002). The first change within the RM approach to research and evaluation is to extend the time frame under which judgments of efficacy and effectiveness are rendered (White, Boyle & Loveland, 2002). Evidence that short-term effects of intervention (e.g., brief periods of sobriety) predict later therapeutic outcomes (e.g. sustained recovery) (see Weisner, et al, 2003) tells only part of the story. Time-related deterioration of effects, delayed positive effects and delayed iatrogenic (harmful) effects of service interventions can only be identified via longitudinal studies. It is also possible that multiple interventions into chronic disorders may have cumulative or synergistic effects (from particular service combinations and sequences) not identifiable through the evaluation of a single service episode.

Because RM is based on a long-term health management partnership with individuals, families and communities, it calls for a heightened level of sensitivity to constituency attitudes toward scientific research. In communities of color, researchers encounter two significant issues: 1) the distrust of culturally-dominant research, and 2) different ways of knowing.

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 Americans 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 (Westermeyer, 1974; Leland, 1976) to the myth of racial invulnerability of Asians (O'Hare and Tran, 1998). 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 (See Frank, Augustyn, Knight, et al, 2001). They have been shamed by research designs and interpretations that dramatized the problems within communities of color while ignoring their strengths and resiliencies (Coyhis & White, 2002). Observers from within ethnic communities (Casas, 1992) 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.

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 (Hermes, 1998). It will require plotting the long-term pathways of addiction recovery in communities of color. It will require coming to grips with different ways in which communities of color determine what is true and what works in the addiction recovery arena. Most significantly, it will shift ultimate ownership of research from academic and funding institutions to the community being studied.

*Scientific knowledge* assumes that truth can be discovered through professional observation and the rational analysis of findings from controlled experiments. It is predicated on distance and objectivity (knowledge from outside) and is judged to exist only when it has been documented in writing, subjected to professional peer review, and independently replicated. There are two other ways of knowing within communities of color, and these exist more in oral tradition than in written words. The first, historical/cultural truth, asks, "What has been our past experience on this issue?" Racial memory is an important source of knowledge in communities of color—a source that seems alien to the highly individualist values and "now" orientation of the dominant American culture. Within communities of color, community elders rather than scientists are the ultimate authorities.

The second way of knowing, *experiential knowledge*, is based on the contemporary experiences of individuals, kinship networks and fellow community members. This way of knowing tends to be concrete, pragmatic, holistic, and commonsensical (Borkman, 1976). Word-of-mouth knowledge, captured in the collective stories of a community or a people, constitutes a key source of truth in communities of color. Communities of color do not reject science as much as require that its findings be filtered through the sieve of personal and community experience. In contrast to scientific knowledge, this way of knowing assumes that truth can only be discovered through proximity and experience (knowledge from inside). Living stories (experiential authority) have more power and cultural credibility than statistics (professional/scientific authority) within many communities of color. Living stories are best viewed as a unique and legitimate type of evidence rather than "myths" or "folklore"

(Hermes, 1998). This does not mean that the usual methods of scientific analysis are abandoned, but that voices of the community are allowed to directly reach those who hear and read about the community through the medium of scientific research.

RM models will be required to pass the litmus test of multiple ways of knowing if they are to achieve credibility within and outside communities of color. The development of evidence-based services is a fundamental tenet of RM, but in communities of color the nature of that evidence will have to be broadened via qualitative studies that capture the historical and contemporary experience within communities of color. RM models in communities of color will also have to shift from an exclusively academic to a more activist orientation (studying questions of importance to the community, focusing on knowledge that can facilitate positive personal, family and community change); enter into a research partnership with the community (e.g., control over design, conduct, interpretation and dissemination), and respect the community's ownership of its own knowledge.

## A Recovery Management Agenda

This paper has contrasted acute care (AC) and recovery management models (RM) models of intervention into serious AOD problems. It is suggested that RM models offer advantages to communities of color in eight specific areas:

- an ecological perspective on the etiology of AOD problems
- a broadened target of intervention (including families, kinship networks and communities)
- a proactive, hope-based model of service engagement
- the inclusion of indigenous healers and institutions
- an expanded menu of culturally-grounded recovery support services and catalytic metaphors
- an extended time-frame of recovery support
- a partnership-based service relationship, and
- a culturally-nuanced approach to research and evaluation.

The reader may ask, "Where are these models of recovery management?" There may not be any treatment organizations that have fully developed all of the elements of RM described in this paper. RM exists as an emerging model whose

service elements are currently being piloted and evaluated. The RM model is being utilized to transform whole behavioral health systems, e.g., the State of Connecticut and the City of Philadelphia. It exists within progressive treatment programs that are experimenting with new approaches to pre-treatment engagement and post-treatment continuing care. The model exists within the growing number of experiments with peer-based recovery support services. It exists within the growing network of peer-managed recovery homes in the United States. And perhaps most significantly, its potential is demonstrated in the growing number of recovery-focused religious and cultural revitalization movements within American communities of color. The challenge is to create connecting tissue between treatment and recovery by building bridges between these indigenous recovery movements and addiction treatment institutions.

RM holds great promise in communities of color, but fulfillment of that promise hinges on:

1) involving clients, families and service professionals from within communities of color in the process of shifting existing interventions from AC models to locally designed, operated and evaluated RM models
2) developing recovery management teams and advocacy coalitions via the integration of AOD service providers and indigenous institutions
3) confronting forces in the community that promote excessive AOD use,
4) enhancing "community recovery capital" (Granfield and Cloud, 1999)
5) increasing the presence and visibility of indigenous sobriety-based support structures
6) providing recovery education within communities of color, and
7) using recovery role models that illustrate the viability and variety of recovery pathways within communities of color.

Achieving that vision will require that the field of addiction treatment fundamentally redefine the sources and solutions to AOD problems and, in the process, redefine itself.

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## Recovery Management Checkups
## A Future Function of Addiction Professionals?

**Christy K. Scott, Ph.D., Michael L. Dennis, Ph.D., & William L. White, M.A.**
**Chestnut Health Systems**

A quiet revolution is unfolding that could fundamentally redefine the character, scope and duration of addiction treatment services. This article reports on the shift from acute care (AC) models of intervention into alcohol and other drug problems to models of sustained recovery management (RM) and summarizes the first research study testing the effects of proactive recovery management checkups on treatment outcomes.

### Historical Context

Addiction has been characterized as a chronic disease for more than 200 years, but it is most often treated in acute episodes of care. This acute care model is characterized by: 1) serial episodes of self-contained, unlinked interventions (ever-briefer detoxification and psychosocial stabilization), 2) the expectation that complete and sustained recovery will follow a single episode of care, and 3) minimal resources devoted to post-treatment continuing care (aftercare as an afterthought). In short, treatment for addiction has resembled treatment of a broken arm or a bacterial infection. An expert diagnoses and treats the problem. The service relationship ends via “graduation” and “discharge” with (at best) a few “aftercare visits,” and the patient is expected to go on with his or her life without further need of professional assistance. Arguments over whether persons in inpatient addiction treatment should stay twenty-eight days or five days, whether outpatient treatment should be five sessions or twenty sessions, or consist of Twelve Step Facilitation or Cognitive Behavioral therapy are all arguments inside this acute care paradigm. The bias towards acute models of care is so pervasive that approaches that have sought more extended periods of support (Alcoholics Anonymous, long-tern therapeutic communities, and methadone maintenance) have often been criticized for this very quality. Moreover, attempts to provide more sustained monitoring and support face significant barriers from managed care limits and service financing models that typically exclude payment for post-treatment monitoring

and support services.

The acute care model of intervention is being challenged by an accumulation of scientific data that is sparking calls for models of sustained recovery management. This latter approach emphasizes the similarities between addiction and other chronic health problems, calls for a shift in emphasis from recovery initiation to recovery maintenance, and wraps traditional treatment in a more extended continuum of recovery management support services and monitoring across episodes of care ((McLellan, O'Brien, Lewis and Kleber, 2000; White, Boyle, Loveland, 2003).

**Scientific Context**

The scientific building blocks of the recovery management model are the product of more than three decades of research on the course of addiction and the effects of addiction treatment. The most critical of these findings include the following.

Pattern Variability Alcohol and other drug (AOD) problems present in varying degrees of severity, complexity and chronicity. Most people who experience less severe AOD problems are able to stop or decelerate use without the assistance of mutual aid groups or professional treatment (King and Tucker, 1998), while others resolve these problems following a single episode of brief professional intervention (Bien, Miller & Tonigan, 1993). Of those whose problem severity reaches the level of AOD "dependence", about half eventually achieve a state of recovery (i.e., no symptoms for 12 or more months) (Kessler, 1994), with most reaching recovery after participating in AOD treatment (Cunningham et al., 1999, 2000).

Determinants of Chronicity Those for whom AOD problems tend to be more enduring are distinguished by greater personal vulnerability (family history of AOD problems, early age of AOD onset, developmental victimization), greater AOD problem severity, greater problem complexity (e.g., co-occurring psychiatric, behavioral, legal, health, and social problems), and lower "recovery capital" (internal and external resources to initiate and sustain recovery) (Granfield and Cloud, 1999).

Cycle of Relapse, Treatment Re-entry and Recovery A sizeable portion of persons entering addiction treatment in the United States are experiencing problems that constitute a chronic AOD condition that typically require multiple episodes of care. Of those entering the public treatment system, 60% report prior treatment (23% 1 time; 13% 2 times, 7% 3 times, 4% 4 times and 13% 5 or more times)(OAS, 2001). Twenty-five to thirty-five percent are readmitted to treatment within twelve months, 50% within 2-5 years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989). Only 1 in 5 clients discharged from addiction treatment participates in any post-discharge continuing care (McKay, 2001). Continuing care consists mostly of passive referral to mutual aid groups, but exposure to such groups without ancillary supports results in high attrition rates (50% in first three months) (Mäkelä, et al, 1996). In short, most clients are precariously balanced between recovery and relapse in the weeks and months following acute treatment, and have few pro-recovery professional or peer supports during this period. Post-treatment relapse and treatment

readmission are the most common outcomes.

Addiction and Recovery Careers Of those treated for substance dependence who go on to achieve sustained abstinence, most will experience 3-4 episodes of acute care over a span of eight years before reaching this goal (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Funk, 2003). Addiction recovery begins prior to the cessation of drug use; is marked in its earliest stages by extreme ambivalence, involves age-, gender-, and culture-mediated change processes; and involves predictable stages, processes, and levels of change (Prochaska, et al., 1992). Those factors that maintain recovery over the long run are often different than those factors that initiate recovery (Humphreys, Moos & Finney, 1995). Recovery is enhanced by processes of social support (Humphreys, Mankowski, Moos & Finney, 1999), participation in recovery support groups, (Emrick, Tonigan, Montgomery, & Little, 1993), and by sobriety-conducive living environments (Jason, Davis, Ferrari & Bishop, 2001). Recovery durability (point at which risk of future lifetime relapse drops below 15%) is not reached until 4-5 years of sustained remission (Jin, Rourke, Patterson, Taylor & Grant, 1998).

Cumulative/Timing Effects of Treatment Long-term recovery outcomes are influenced by the age of first treatment admission (the earlier the age of first treatment and the lower the years of regular use, the better the long term outcome) (Dennis, Scott, & Funk., under review), the total amount of treatment received (particularly when the total period of service contact exceeds 90 days) (NIDA, 1999; Simpson et al 2002), and the speed with which re-engagement and readmission to treatment occurs (Scott, Foss & Dennis, 2003). Recovery outcomes can be enhanced through post-treatment follow-up interviews (conducted as part of treatment outcome studies) (Sobell and Sobell, 1981), recovery checkups (Dennis, Scott, & Funk, 2003) and participation in assertive continuing care programs (Godley, Godley, Dennis, Funk & Passetti, 2002).

Chronic Disease Management Service models involving sustained tracking, monitoring (via regular checkups), patient motivation and support, and early re-intervention and service linkage play a central role in the management of such chronic conditions as asthma, cancer, diabetes mellitus, hypertension and severe mental illness. These conditions are similar to addiction in their etiological complexity (interaction of genetic, biological, psychological and physical/social environmental factors), course, and clinical outcomes. There are increasing calls to apply technologies used in the management of such disorders to the treatment of severe and persistent AOD problems (McLellan, et al, 2000; White, et al, 2003).

These cumulative research findings suggest redesigning addiction treatment to speed problem identification and engagement, reduce attrition during treatment, increase participation in continuing care, and provide a proactive approach to post-treatment monitoring, stage-appropriate recovery education, sustained recovery support, active linkage to local communities of recovery and early re-intervention. It will be up to the addictions research infrastructure to judge whether such innovations significantly enhance long-term treatment and recovery outcomes.

## A Clinical Test

A just-published scientific study tested the effects of a quarterly Recovery Management Checkup (RMC) model over a two-year period with a group of clients entering a central intake unit in Chicago (Dennis, Scott & Funk, 2003). These clients brought many risk factors for post-treatment relapse, e.g., psychiatric co-morbidity (77%), substance use by others in the home (40%), regular substance use by peers (84%), and history of homelessness (54%). A total of 448 clients (59% female; 85% African American; primarily dependent upon cocaine, opiates and alcohol) were randomly assigned to the recovery management checkup (RMC) protocol or a control condition. Those in the RMC group were interviewed quarterly and, when determined to be in need of treatment, were provided a Linkage Manager who conducted a motivational interview and assisted with re-entry into treatment. The control group received only quarterly interviews but no active linkage to treatment.

The study found that those clients assigned to RMC were more likely than those in the control group to return to treatment (64% vs. 51%), to return to treatment sooner (376 vs. 600 days), and to spend more subsequent days in treatment (mean of 62 vs. 40 days). RMC participants also experienced significantly fewer total quarters in need of treatment and were less likely to need treatment 2 years after intake (43% vs. 56%). The study offers support to calls to shift addiction treatment from acute episodes of care to long-term recovery management across episodes of care. Recovery checkups constitute a means of linking and improving such episodes of care. This experimental evaluation of RMC tested three specific elements of the larger model of recovery management – monitoring, motivational interviewing and linkage assistance. While the results are positive, they also indicate areas for further improvement. For instance, only 60% of the linked participants remained in treatment 14 or more days. Given that individuals who stayed 14 or more days were significantly more likely to end the quarter in recovery (26% vs.16%), improving engagement and retention rates is clearly one of the challenges for a second experiment currently under way. Other possibilities might include a separate recovery management treatment track (versus recycling clients through the same "program"), use of recovery coaches, and linkage to a broader spectrum of recovery support services (e.g., active linkage to communities of recovery, recovery homes).

## Recovery Management and the Future of Addiction Treatment

The goal of recovery management is the optimum level of global health and functioning of individuals experiencing alcohol and other drug dependence–a goal achieved by many through full and sustained symptom remission and for others through decreased frequency and intensity of AOD use and related problems and strengthened periods of remission and recovery. The vision is one of empowering individuals, families and service professionals to proactively manage such disorders over their entire course.

A significant number of citizens with chronic AOD disorders are being offered brief interventions that, as currently designed, do little to alter their addiction careers or empower them to

achieve stable recovery. There are growing challenges to this acute intervention model and calls for models of sustained recovery management that more closely resemble the sustained care and support afforded other chronic medical and mental disorders. These new models call for integrating recovery support services across the continuum of care, with a particular emphasis on sustained monitoring, stage-appropriate recovery education, recovery coaching and, when necessary, early re-intervention.

For those with the most severe AOD problems, multiple episodes of detoxification and stabilization are more likely to constitute brief respites within their addiction careers than a doorway to long-term recovery. Changing that will require fundamentally rethinking how and when addiction professionals intervene in the lives of those suffering from these disorders. If the addiction treatment field really believed that addiction was a chronic disorder, addiction counselors would be encouraged to function as long-term professional allies in the recovery process, and recovery management checkups would be a routine component of a sustained continuum of recovery support services.

For the frontline addiction professional, studies such as the one described here suggest a greater emphasis on building sustained recovery support from the treatment setting into the client's natural environment. This could be achieved in four ways: 1) advocating for models of sustained recovery management, 2) expanding one's knowledge of culturally indigenous recovery support structures, 3) using more assertive methods of linking clients to post-treatment recovery support resources, and 4) (where possible) providing post-treatment monitoring, stage appropriate recovery coaching and early re-intervention. The challenge for addiction professionals working within acute intervention models is to find creative ways to extend the continuity of recovery support beyond the ever-briefer episodes of care that currently characterize addiction treatment.

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# GLATTC BULLETIN

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# RECOVERY MANAGEMENT: WHAT IF WE REALLY BELIEVED THAT ADDICTION WAS A CHRONIC DISORDER?

## INTRODUCTION

A quiet revolution is unfolding within the worlds of addiction treatment and recovery support. This revolution is founded on new understandings of the nature of substance use disorders and their management. It calls for shifting the treatment of severe and persistent alcohol and other drug (AOD) problems from an emergency room model of acute care (AC) to a model of sustained recovery management (RM). The RM model wraps traditional interventions in a continuum of recovery support services spanning the pre-recovery (recovery priming), recovery initiation and stabilization, and recovery maintenance stages of problem resolution. Particularly distinctive is the model's emphasis on post-treatment monitoring and support; long-term, stage-appropriate recovery education; peer-based recovery coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention.

## SECTION I: PROMOTIONAL FORCES

There are several forces pushing the addiction field toward a redesign of its treatment processes. Frontline addiction professionals are articulating (and a growing number of scientific studies are confirming) the limitations of addiction treatment as currently practiced. Grassroots recovery advocacy organizations are calling upon the treatment industry to reconnect professional treatment to the larger and more sustained process of addiction recovery. Pioneer states (e.g., Connecticut) are building research, clinical, and recovery advocacy coalitions to infuse the recovery management model into new "recovery-oriented systems of care." And finally, technological advances in the management of primary chronic health care problems (e.g., diabetes, heart disease, asthma, arthritis, cancer, chronic lung disease, glaucoma, irritable bowel syndrome) are suggesting alternative approaches through which severe and complex behavioral health disorders might be managed more effectively.

## PREMISES

The shift from acute care to sustained recovery management models rests upon six propositions.

1. *Alcohol and other drug problems present in transient and chronic forms.* The transient forms vary in intensity, from the clinical (*substance abuse* and *substance dependence*) to the subclinical (problems not meeting DSM-IV criteria for abuse or dependence). Transient forms share a short duration (a single episode or period of problematic use) and a propensity for natural resolution or resolution through brief professional intervention. Transient

## BIOGRAPHICAL SUMMARY



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AOD problems are common in community populations, but are more rarely represented among populations entering addiction treatment. Compared to community populations, clients entering addiction treatment are distinguished by:

- greater personal vulnerability (e.g., family history of substance use disorders, early age of onset of AOD use, developmental trauma)
- greater severity and intensity of use and related consequences
- high concurrence of medical/psychiatric illnesses
- greater personal and environmental obstacles to recovery
- less "recovery capital" (the internal and external resources required to initiate and sustain recovery)

2. *The evidence is overwhelming that the course of severe substance use disorders and their successful resolution (addiction, treatment, and recovery careers) can span years, if not decades.* Alcohol and other drug dependencies resemble chronic disorders (e.g., type 2 diabetes mellitus, hypertension, and asthma) in their etiological complexity (interaction of genetic, biological, psychological, and physical/social environmental factors), onset (gradual), course (prolonged waxing and waning of symptoms), treatment (management rather than cure), and clinical outcomes. To characterize addiction as a chronic disorder is not to suggest that recovery is not a possibility. There are millions of people in stable, long-term recovery from addiction. The notion of addiction as a chronic disorder does, however, underscore the often-long course of such disorders and the sustained "treatment careers" that can precede stable recovery. Recent studies have confirmed that the majority of people with severe and persistent substance use disorders (i.e., substance dependence) who achieve a year of stable recovery do so following 3-4 treatment episodes over a span of eight years.

3. *Severe and persistent AOD problems have been collectively depicted as a "chronic, progressive disease" for more than 200 years, but their historical treatment more closely resembles interventions into acute health conditions (e.g., traumatic injuries, bacterial infections).* If we (the practitioners of addiction treatment) really believed addiction was a chronic disorder, we would not:

- view prior treatment as predictor of poor prognosis (and grounds for denial of treatment admission)
- convey the expectation that all clients should achieve complete and enduring sobriety following a single, brief episode of treatment
- punitively discharge clients for becoming symptomatic
- relegate post-treatment continuing care services to an afterthought
- terminate the service relationship following brief intervention
- treat serious and persistent AOD problems in serial episodes of self-contained, unlinked interventions

4. *Acute models of treatment are not the best frameworks for treating severe and persistent AOD problems.* The limitations of the acute model of addiction treatment as currently practiced include:

- Failure to Attract: Less than 10% of U.S. citizens who meet DSM-IV criteria for substance abuse or dependence currently seek treatment, and most of those admitted to treatment arrive under coercive influences.
- Failure to Engage/Retain: More than half of the people admitted to addiction treatment in the U.S. do not successfully complete treatment, and 18% of people admitted to addiction treatment are administratively discharged from treatment.
- Inadequate Service Dose: A significant percentage of individuals completing treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.
- Lack of Continuing Care: Post-discharge continuing care can enhance recovery outcomes, but only one in five clients actually receives such care.
- Recovery Outcomes: The majority of people completing addiction treatment in the U.S. resume AOD use in the year following treatment, most within 90 days of discharge from treatment.
- Revolving Door: Of those admitted to publicly funded addiction treatment, 60% already have one or more prior treatment admissions, and 24% have three or more prior admissions. Between 25% and 35% of clients who complete addiction treatment will be re-admitted to treatment within one year, and 50% will be re-admitted within 2-5 years.

A large number of people are undergoing repeated episodes of brief interventions whose designs have little ability to fundamentally alter the trajectory of substance dependence and its related consequences. This failure does not result from client foibles or the inadequate execution of clinical protocol by service professionals. It flows instead from a fundamental flaw in the design of the intervention - an acute-care model of treating addiction that is analogous to treating diabetes or asthma through a single, self-contained episode of inpatient stabilization. In the AC model, brief symptom stabilization is misinterpreted as evidence of sustainable recovery.

5. *Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months, and years following treatment.* Recent studies have confirmed the fluidity of post-treatment adjustment. One such study 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. Beyond the groups of clients who categorically succeed or do not succeed stands a larger body of clients who vacillate between periods of recovery and periods of re-addiction. The precarious nature of early recovery is further confirmed by longer-term studies finding

that stable recovery from alcoholism (the point at which the future risk of lifetime relapse drops below 15%) is not achieved until 4-5 years of continuous recovery, and that stable recovery from opiate addiction takes even longer. Such findings beg for models of sustained post-treatment monitoring and support.

## PROMISES AND PROSPECTS

Recovery management models hold great promise in treating severe and complex substance use disorders. Chronic disorders are disorders that resist cure via brief intervention but can often be successfully managed (the achievement of full or partial recovery). Such management entails care and sustained support aimed at enhancing the strength, quality, and durability of remission periods and shortening the frequency, duration, and intensity of relapse episodes. This longer-term vision of the treatment and recovery process is based on several critical assumptions:

1. A single brief episode of treatment rarely has sufficient effect for those with the most severe substance use disorders (i.e., substance dependence) to sustain recovery following the intervention.
2. Multiple episodes of treatment, if they are integrated within a recovery management plan, can constitute incremental steps in the developmental process of recovery.
3. Treatment episodes over time may generate cumulative effects.
4. Particular combinations and sequences of professional treatment interventions and peer-based recovery support services may generate synergistic effects (dramatically elevated long-term recovery outcomes).

RM models are focusing initially on the power of post-treatment monitoring and recovery support services. Early studies are confirming the potential utility of such approaches. One study of recovery management checkups (RMC) and early re-intervention over 24 months following treatment found that members of the RMC group had significantly fewer post-treatment days of substance use, were more likely to return to treatment, were more likely to return to treatment sooner, received treatment on a greater number of days following discharge from the index episode, and experienced fewer quarters during follow-up in which they were in need of treatment.

Treating alcohol and other drug dependence solely through repeated episodes of detoxification and brief stabilization is clinically ineffective and constitutes a poor stewardship of personal and community resources. It contributes to the pessimism of clients, service providers, policy makers, and the public regarding the prospects for permanent resolution of alcohol and other drug problems. It is time we acted as if we really believed addiction was a chronic disorder. Today millions of people are reaping the fruits of recovery while others continue to suffer. It is time we widened the doorway of entry into recovery for those with the most severe and persistent substance use disorders. To achieve that will require changes in our thinking, changes in our clinical technologies, and changes in systems of service reimbursement.

## SECTION II: MODEL DEFINITION

The recovery management model of addiction treatment shifts the focus of care from professional-centered episodes of acute symptom stabilization toward the client-directed management of long-term recovery. It wraps traditional interventions within a more sustained continuum of:

1. pre-recovery support services to enhance recovery readiness
2. in-treatment recovery support services to enhance the strength and stability of recovery initiation, and
3. post-treatment recovery support services to enhance the durability and quality of recovery maintenance.

The influence of this emerging model is evident in many quarters. It is evident in the research community's exploration of addiction as a chronic disease (O'Brien & McLellan, 1996; McLellan, Lewis, O'Brien & Kleber, 2000). It is reflected in the work of the Behavioral Health Recovery Management project in Illinois (White, Boyle & Loveland, 2003a/b) and other pioneer state efforts to reshape addiction treatment into a "recovery oriented system of care" (e.g., see http://www.dmhas.state.ct.us/recovery.htm). Interest in recovery management at the federal level is revealed in the move toward a more recovery-oriented research agenda at NIAAA and NIDA, in SAMHSA and CSAT's growing interest in peer-based models of recovery support services (particularly within CSAT's Recovery Community Support Program), and in the White House-initiated Access to Recovery program. Private sector interest in recovery-focused treatment system enhancements is reflected in the Robert Wood Johnson's Paths to Recovery Initiative (http://www.pathstorecovery.org). The shift from acute intervention models to models of sustained recovery support are further reflected in the policy agendas of new grassroots recovery advocacy organizations across the country (see http://www.facesandvoiceofrecovery.org).

Describing the emerging "model" of recovery management is a bit like describing a painting while it is being created, but there are broad principles and early changes in clinical practices that are becoming visible.There may be no single program in the country that reflects all the changes described below, but these changes do collectively represent what is increasingly being characterized as a model of *recovery management*.

## MODEL PRINCIPLES

There are several cornerstone beliefs that distinguish the recovery management model from acute models of addiction treatment. These principles and values include:

1. emphasis on resilience and recovery processes (as opposed to pathology and disease processes)
2. recognition of multiple long-term pathways and styles of recovery
3. empowerment of individuals and families in recovery to direct their own healing
4. development of highly individualized and culturally nuanced services
5. heightened collaboration with diverse communities of recovery, and

6. commitment to best practices as identified in the scientific literature and through the collective experience of people in recovery. (http://www.bhrm.org/papers/principles/BHRMprinciples.htm and http://www.dmhas.state.ct.us/corevalues.htm)

## MODEL PRACTICES

White, Boyle and Loveland's (2003a/b) review of recovery management (RM) pilot programs reveals several critical differences between the RM models and traditional acute care (AC) models of intervention. These differences span seven broad areas of clinical practice.

Engagement and Motivational Enhancement: RM models place great emphasis on engagement and motivational enhancement. This emphasis is reflected in low thresholds of engagement (inclusive recruitment and admission processes), an investment in outreach and pre-treatment support services, and high retention and low post-admission extrusion (administrative discharge) rates. Within the RM model, motivation is viewed as an important factor in long-term recovery, but is viewed as something that emerges within the service relationship rather than a precondition for service initiation. This emphasis is based on two premises: 1) chronic disorders increase in complexity and severity over time, and 2) recovery outcomes are enhanced by the earliest possible point of recovery initiation and stabilization. AC models of addiction treatment are essentially reactive in their wait for individuals to enter states of crisis that bring them to treatment. RM models reach out to people prior to such crises and sustain contact with them to re-nurture motivation for recovery following such crises.

Assessment and Service Planning: In traditional treatment, the clinical assessment is categorical (focused on substance use and its consequences), is pathology-based (focused on the identification and elucidation of problems), and is an intake activity. Problem severity dictates level of care, and the problems list drives the development of the treatment plan. In recovery management models, assessment is global (focused on the whole life of the recovering person), asset-based (focused on recovery capital - internal and external assets that can help initiate and sustain recovery), and is continual over the span of the service relationship. This altered view of the assessment process is based on three propositions:

1. Chronic disorders beget other acute and chronic problems, therefore all aspects of the life of the recovering person must be assessed and incorporated into an integrated recovery process.
2. Service intensity and duration is dictated by the interaction of problem severity and recovery capital, therefore problem severity alone is an inadequate and disempowering framework for service planning,
3. There are developmental stages of long-term recovery and service and support needs can shift dramatically in the transition from one stage to another, therefore stage-dependent service needs must be continually reevaluated.

The traditional professionally-directed, short-term treatment plan of the acute care model is replaced in the RM model by long-term and short-term recovery plans prepared by the person seeking recovery. The former focuses primarily on reducing pathology; the latter focuses on building recovery capital and a meaningful life.

Service Duration and Emphasis: Acute care models do an excellent job of biopsychosocial stabilization, but often fail to facilitate the transition between recovery initiation and recovery maintenance. The evidence of such failure can be found in post-treatment relapse and treatment re-admission rates (see Section 1). Recovery management models rest on the assumption that the factors required to sustain recovery over a lifetime are different than those factors that spark brief sobriety experiments. The recovery management model emphasizes four post-treatment service activities: sustained post-stabilization monitoring, stage-appropriate recovery education and coaching, assertive linkage to local communities of recovery, and, when needed, early re-intervention. Detoxification and traditional treatment exist within RM models, but the focus of service shifts from crisis intervention to post-treatment recovery support services.

Locus of Services: The institutional focus of the acute care model ("How do we get the addicted person into treatment?") shifts within the RM model to the larger community ("How do we nest the process of recovery within the client's natural environment?"). With this shift, there is a greater emphasis on home- and neighborhood-based services and in direct monitoring technology (e.g., telephone, mail, Internet), as well as an emphasis on organizing indigenous recovery support services within the client's physical and social environment.The RM model also pushes treatment agencies toward greater advocacy responsibilities related to stigma and discrimination, the removal of environmental obstacles to recovery and the development of needed recovery support resources within local communities.

Role of the Client: In acute care models of intervention, the person entering treatment is viewed as the major obstacle to his or her own recovery, and thus is dependent upon an expert who assumes fiduciary responsibility for diagnosis and treatment. RM models champion the necessity and right of the person who is seeking recovery to self-manage his or her own recovery process. Each client must become an expert on his or her condition and its management. This emphasis is reflected in the client's role in service planning and evaluation as well as in the RM model's inclusion of recovering people and family members in policy-making positions and as volunteers and paid service providers.

Service Relationship: The service relationship within the RM model shifts from one that is hierarchical, time-limited, and highly commercialized (the AC model) to one that is less hierarchical, more time-sustained and more natural. In the RM model, the service provider role is more that of a teacher and ally within a long-term health care partnership. RM models are also pioneering new approaches to peer-based recovery support services that utilize new service roles, e.g., peer counselors, recovery coaches, recovery support specialists (White, 2004). The RM model

emphasizes the importance of sustained continuity of contact in a primary recovery support relationship. This relationship would be analogous to the long-term alliance between a primary care physician and his or her diabetic patient or the long-term support that exist within addiction recovery mutual aid societies.

Model Evaluation: The evaluation of acute care models of addiction treatment focuses on measuring the short-term effects of a single, brief episode of intervention. Evaluation within the RM model focuses on measuring the long-term effects of multiple service interventions. The goal is to identify particular combinations or sequences of clinical and recovery support services that generate dramatically elevated (cumulative or synergistic) effects upon recovery outcomes within particular populations of people. The RM model also balances science-based evaluations of service outcomes with consumer and community/tribal evaluations of service processes and recovery outcomes.

Today, elements of the RM model exist within many traditional treatment programs that have evolved toward more client-responsive clinical policies and practices. Elements of the model exist within CSAT's Recovery Community Support Program and RWJ's Paths to Recovery grantee sites. The model is being tested within research studies that are evaluating elements of the RM model. It exists within the growing network of recovery homes and recovery support centers. The recovery management model of intervening with severe substance use disorders marks a dramatic change in the design of addiction treatment in the United States. Time will tell whether this model will struggle as a loosely attached appendage to the existing system of addiction treatment or whether it will transform addiction treatment in the United States into a truly recovery-oriented system of care and long-term support.

## SECTION III: IMPLEMENTATION CHALLENGES

The scientific evidence documenting the need to shift addiction treatment from an acute model of intervention to a model of sustained recovery management is so overwhelming it leaves one wondering why this model is not yet fully implemented. The roots of this failure are historical, conceptual, financial, organizational and technical.

The first barriers to treating addiction as a chronic disorder are the forces of historical and conceptual momentum. The modern field of addiction treatment is rooted in an acute biopsychological model of intervention. Addiction treatment programs were created in the image of the acute care hospital (via the profound influence of hospital-derived accreditation standards). The central service role in addiction treatment was similarly modeled after the therapy disciplines of psychiatry, psychology and social work (via addiction counselor certification and licensure standards). For those of us steeped in the modern world of addiction treatment, it is almost impossible to think of treatment in terms other than number of days or number of sessions, and hard to think about continuing care as anything beyond the availability of a short regimen of "aftercare" sessions. We have viewed addiction treatment in terms of multiple levels of care and theory-based modalities, but have failed to recognize that all of these approaches are nested within an acute care model of assess, admit, treat and discharge. To escape this closed conceptual world, programs exploring the RM model are re-educating their service workers and are conducting a rigorously honest, recovery-focused inventory of their current service practices.

All of the reimbursement and regulatory systems that govern addiction treatment are based on the acute care model. These structures, originally designed to elevate the consistency and quality of addiction treatment, now constitute a major barrier to shifting to more recovery-oriented systems of care. When programs embracing the RM philosophy seek to admit families rather than individuals, create multi-agency service teams that include indigenous institutions and cultural healers, utilize long-term recovery plans rather than short-term treatment plans, incorporate peer-based recovery support roles/teams, develop non-clinical recovery support systems in local communities, and provide long-term monitoring and early re-intervention services, they find themselves facing almost insurmountable fiscal and regulatory barriers. It is tragic and ironic that the major challenges of recovery management are posed, not by the complex needs of individuals and families seeking recovery, but by the systems originally set up to help facilitate that recovery. The mainstream implementation of recovery management will require a major overhaul of the reimbursement and regulatory systems governing addiction treatment. States like Connecticut that have begun this overhaul process are making a significant contribution to the future of addiction treatment and recovery in America (http://www.dmhas.state.ct.us/recovery.htm).

Slowing the development and implementation of RM models are the weak organizational infrastructures and high staff turnover rates that pervade the world of addiction treatment (McLellan, Carise, & Kleber, 2003). RM is founded on the continuity of relationship between an organization and the communities it serves and the capacity for sustained continuity of contact between each organization's front line service professionals and the individuals and families within those communities who suffer from severe and persistent AOD problems. If there is an Achilles heel of the RM model, it is in the combined effects of organizational instability and staff turnover within the addictions field (Roman, Blum, Johnson, & Neal, 2002). If the process of RM is to parallel that of the long-term relationship between a primary care physician and a patient/family impacted by a chronic disease, that instability and turnover must be reversed.

The lack of a science-based understanding of long-term recovery constitutes a significant obstacle to the design of RM programs. As a field, our scientific knowledge about addiction and brief models of treatment has grown exponentially in recent decades, but our science has yet to connect the problem and the intervention to the process of long-term recovery. We know comparatively little from the standpoint of science about the prevalence, pathways and styles of long-term recovery. The ability to find potent combinations and sequences of professionally-directed treatment interventions and peer-based recovery support services rests on the emergence of a recovery

research agenda at the federal level. Without scientific data, RM pioneers will lack a reliable compass to navigate the recovery frontier.

A fifth obstacle in implementing RM models of care involves the integration of professional-directed treatment services and peer-based recovery support services (particularly within the newly emerging role of recovery coach). Questions abound related to such integration. Are recovery support services best provided by addiction treatment organizations or by free-standing recovery support and recovery advocacy organizations? Should recovery support services be added to the role of addiction counselor or segregated within a new specialized role? What are the best ways to recruit, train and supervise recovery support specialists? What are the boundaries of competence of these new recovery support specialist roles, and how do they fit into larger multidisciplinary teams? Which models of integrating or coordinating professional and peer-based recovery support services are associated with the best long-term recovery outcomes? Answers to such questions are crucial to the future evolution of the RM model, and their absence constitutes a major implementation obstacle.

The service capacity of an organization or service professional within the RM model has yet to be clearly defined. If, for example, an addiction counselor is responsible for providing on-going monitoring and support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention services for those leaving traditional inpatient or outpatient treatment, what is a reasonable caseload for such a counselor? The answer is that we don't know. RM will require a significant reallocation of resources - a shift that will de-emphasize expensive, high intensity acute care and emphasize lower-intensity, lower cost and more enduring recovery support services. Service capacities for organizations and individual workers will have to be redefined in that transition.

The ethical guidelines that have guided addiction treatment agencies and addiction counselors for the past three decades grew out of the acute care service relationship and were closely modeled after the ethical guidelines for psychologists and social workers (e.g., discouragement or prohibition of self-disclosure, prohibition of all dual relationships, prohibition of gifts, etc.). These guidelines, which presupposed a short-term, expert-based fiduciary service relationship, do not easily fit the less hierarchical and more enduring service relationships that characterize the RM model. It is crucial that ethical standards evolve to guide the provision of professionally-delivered and peer-based recovery support services. The lack of current ethical guidelines for recovery support services raises the ethical vulnerability of service organizations and service professionals.

## POTENTIAL PITFALLS

This three-part series on the recovery management model of addiction treatment and recovery support would be incomplete without an exploration of some of the potential pitfalls of the RM model. Experience to date suggests three potential pitfalls beyond the implementation challenges noted above.

Not everyone with an AOD-related problem needs RM services. Many individuals with such problems will resolve these problems on their own or will do so through mutual aid or brief professional intervention. Misapplying an RM model to persons with low problem severity and high recovery capital could generate iatrogenic effects within the RM model. Such misapplication could injure persons with transient AOD problems by inappropriately attaching a stigma-laden diagnosis and delivering services that are ineffective, a financial burden and potentially harmful.

The emphasis on addiction as a chronic disorder within the RM model could inadvertently contribute to cultural pessimism about the resolution of AOD problems and heighten the stigma and discrimination attached to those problems (Brown, 1998). To counter such effects, RM models must constantly emphasize the reality of full recovery in the lives of millions of people who have suffered from severe and prolonged AOD problems.

The 1980s witnessed a period of institutional profiteering in which persons with alcohol and other drug problems were viewed as a crop to be harvested for financial profit. A too rapid shift to RM models of reimbursement could unleash the same forces. Profiteers could garner large, capitated contracts for recovery support services, but then minimize the services delivered through such contracts to maximize institutional and personal profit. These profiteers could escape accountability for recovery outcomes behind the rhetoric that addiction is a chronic disease. To avoid this, RM models of reimbursement must include a high level of accountability for recovery outcomes. This will require clinical information systems that can track clinical outcomes and other performance indicators across multiple episodes of care.

Attempts to shift addiction treatment from a revolving emergency room door (via unending cycles of brief intervention) to a model of sustained recovery management face many implementation obstacles and potential pitfalls. These obstacles and pitfalls are offset by the potential of the RM model to align the design of addiction treatment with the growing body of scientific evidence documenting the chronicity of severe AOD problems and the complexity of long-term recovery. That potential and what it means for millions of people suffering from addiction will inspire many addiction professionals and addiction treatment organizations to experiment with this fundamental redesign of addiction treatment.

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The major components include the application of evidence based treatments coupled with longitudinal recovery support as an alternative to the acute interventions that characterize traditional behavioral health approaches. In addition, the project emphasizes a consumer-centered, strengths-based service delivery model.

The project is a partnership of Fayette Companies located in Peoria, Illinois and Chestnut Health Systems headquartered in Bloomington, Illinois and the University of Chicago, Center for Psychiatric Rehabilitation in Chicago, Illinois. Funding is provided by the Illinois Department of Human Service's Office of Alcoholism and Substance Abuse.

A full description of the project is can be obtained at: http://www.bhrm.org/bhrmpsummary.pdf.

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## Chronic Addiction and Recovery Management: Implications for Clinical Practice

**Christy Scott, Ph.D., William White, MA, and Michael L. Dennis, Ph.D.**
Chestnut Health Systems

In 2001, Dr. Lonnie Shavelson published *Hooked*, a provocative study of the lives of five individuals whose addictions propelled them through multiple episodes of addiction treatment and encounters with a host of other community institutions. Shavelson's ethnography of addiction was in part an exposé of a treatment system that failed to comprehend and respond to the chronic and complex nature of addiction and recovery. This article summarizes the empirical evidence that addiction is for many a chronic condition, identifies risk factors for such chronicity, highlights the consequences of treating chronic addiction in the context of an acute care model, and notes the emergence of sustained recovery management models as well as the clinical implications of such models.

### Addiction: Acute or Chronic Condition?

Community surveys reveal high lifetime consumption of alcohol and other drugs in the general population and the existence of substantial numbers of people with transient AOD-related problems who resolve these problems without the aid of professional treatment or recovery support groups. Clinical studies, however, reveal people with more severe and chronic conditions who are unlikely to recover without such assistance and support. There is growing evidence that many individuals in this latter group experience prolonged cycles of addiction, recovery, relapse, and repeated treatments before achieving stable recovery or experiencing permanent disability or death (Anglin et al., 1997; Dennis, Scott et al., 2005; Scott, Foss et al., 2005b). The evidence of chronicity among the population admitted to publicly funded addiction treatment is striking.

Most people entering publicly funded addiction treatment in the United States have prolonged histories (measured in years and decades) of AOD problems prior to their first admission to treatment (Dennis et al., 2005).

- While the majority of people with lifetime substance dependence eventually enter sustained recovery (i.e., no symptoms for the past year) (Dawson, et al., 2005), most do so after participating in multiple episodes of treatment. Dennis, Scott, and colleagues (2005) recently found that

the median time from first use to a year of abstinence was 27 years; the median time from first treatment to a year of abstinence was 9 years, which included 3 to 4 episodes of treatment.

- Of the people admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment (including 23% for the second time, 22% 3-4 times, and 19% 5 or more times) (OAS, 2005).
- The majority of individuals discharged from addiction treatment will relapse within 3 to 12 months after discharge, most within 30-90 days (Wilbourne & Miller, 2003; Hubbard, Flynn, Craddock, & Fletcher, 2001; Scott et al., 2005b). Instability of recovery continues throughout the early years of recovery (Scott et al., 2005a).
- Post-treatment recovery outcomes are compromised by the low rate of participation in continuing care activities following discharge and the substantial drop-out rate of recovery support group participation in the year following treatment (McKay, 2001).

Findings such as these have prompted leading researchers to speak of addiction and treatment "careers" (Anglin et al., 1997) call for the reconceptualization of addiction as a chronic disorder on par with cancer, diabetes, asthma, and hypertension (McLellan et al., 2000; Scott & Dennis, 2006; Dennis & Scott, in press), and advocate a shift to models of sustained recovery management similar to those used in the treatment of other chronic diseases (White et al., 2002).

## Factors Contributing to the Chronicity

Prolonged complex service histories are especially prevalent when addiction is accompanied by medical, psychiatric, and other problems—a significant finding given the high rate of co-occurring disorders among those entering addiction treatment. Relative to people with lower severity, those who have more chronic substance use disorders are characterized by:

- Greater personal vulnerability (e.g., family history of AOD problems, early age of onset of AOD use/problems, developmental trauma),
- Greater problem severity (e.g., amount of use, number of abuse/ dependence symptoms),
- Greater problem complexity (e.g., co-occurring medical/psychiatric illness, personal and environmental obstacles to recovery, enmeshment in a culture of addiction), and
- Lower recovery capital (e.g., fewer internal and external assets that can be used to initiate and sustain recovery) (White et al., 2002).

## Chronic Conditions and Acute Models of Care

Historically, most health care systems, including substance abuse treatment, have been organized around an episodic relationship in which a person seeks help, is diagnosed and treated, and is discharged and presumed to be cured—all in a relatively short period of time. In the addictions field, policy makers, funders, clinicians, patients and their families, and the public often have the unrealistic expectation that all patients entering addiction treatment should achieve and maintain lifelong abstinence following a single, ever-briefer episode of specialized treatment. The earlier noted post-treatment relapse rates invalidate this assumption and challenge the adequacy of an acute care model of treatment for individuals suffering from chronic substance use disorders. Unlike conditions or illnesses that are time-limited and treatable in single episodes of acute care, chronic conditions ebb and flow over long periods of time, and their course is not

fundamentally altered by acute episodes of stabilization.

Treating chronic conditions in the context of an acute care model can harm service consumers, service professionals, and service organizations. Clients become demoralized, give up on themselves, and may give up on professional treatment. Family members, friends, employers, judges, probation officers, child welfare workers, professional licensing boards, and others become frustrated by frequent relapse and attribute relapses to willful recalcitrance. Unrealistic expectations of treatment often result in clients being punished for their inability to establish instant and permanent sobriety. Facing repeated relapse, clinical staff can also become demoralized and avoid confronting the client's or their own self-perceived "failures" by refusing to re-admit the client or shaming the client at re-admission. If addiction treatment is evaluated based on the short-term expectations of the acute care model, then everyone, including the public and policy makers, risks disillusionment regarding the effectiveness of addiction treatment.

It is our contention that treatment "works" but not in the way many have presumed it should (i.e., that a single episode of care is a self-contained fix for severe AOD problems) and that it could "work" better if the treatment model better matched the growing understanding of the condition. In the next section, we briefly review some of the more recent attempts to shift treatment toward a model of long-term recovery management.

## From Acute Care to Sustained Recovery Management

The shift from acute models of addiction treatment to models of long term recovery management requires changes in service philosophies, significant shifts in service practices, and a transformation in the way addiction treatment and recovery support services are planned, funded, monitored, and evaluated. In states (e.g., Connecticut), cities (e.g., Philadelphia), and research studies (e.g., the Early Re-intervention experiments) where such transformations are underway, it is clear that the shift to a recovery management model entails changes in client engagement strategies, the assessment and service planning process, the service menu, the timing and duration of service delivery, the location of service delivery, the service relationships, and the relationship between treatment institutions and the local communities they serve (White et al., 2002; Dennis & Scott, in press).

One of the most profound changes in this model is its movement beyond brief stabilization to ongoing monitoring and intervention via telephone contact, recovery check-ups and early re-intervention, recovery coaching, and assertive linkage to communities of recovery. Research findings such as the following suggest that more assertive and long-term approaches to managing addiction hold great promise.

- The shorter the time span from first use to first treatment, the shorter the total years of use (Dennis et al., 2005).
- The more severe the substance use disorder, the less likely people are to seek help, but the amount of treatment in any year predicts who moves from addiction to recovery, and the amount of support group participation in any year predicts who stays in recovery (Scott et al., 2005a & b).
- Providing assertive continuing care increases the percentage of clients participating in post-treatment continuing care activities and improves recovery outcomes (Godley et al., 2002, in press).
- Providing recovery management checkups reduces the time from relapse to treatment readmission, increases treatment participation, increases rates of abstinence, and reduces future needs for treatment (Dennis et al., 2003).

Recovery management approaches also hinge on the recognition of multiple pathways and styles of long-term recovery. Such varieties of recovery experience are confirmed in our interviews with thousands of clients conducted months and years following an index episode of treatment. Yesterday's addiction counselor often worked within a particular pathway of recovery; tomorrow's addiction counselors will work across these pathways of recovery emphasizing a philosophy of choice with each client.

## Implications for Clinical Practice

Educate Stakeholders about the Implications of the Chronic and Cyclical Nature of Addiction. Given that many individuals seeking publicly funded treatment have a substance use disorder that will likely span several years and multiple episodes of treatment, educating stakeholders and successfully shifting expectations and attitudes about relapse are primary challenges. Educating clients and their families about the chronic and cyclical nature of addiction may help families sustain their support during times of relapse. Education of treatment staff will help them appropriately attribute relapses to the condition being treated rather than the person and result in less shame for clients and families. In addition, educating policy makers and funders will be crucial to both creating new financing models and changing regulatory standards to accommodate models of sustained recovery management.

Develop new models for treating individuals who need multiple episodes of care. Our current approach to treating chronic substance use disorders often leaves both clients and staff frustrated with burdensome readmission processes and repeated cycles of "treatment as usual" for individuals who return for multiple episodes of care. In fact, one clinical supervisor asked one of our study participants why she returned again and again for treatment when she had already been exposed to their treatment. The supervisor said "there's nothing more for you here." If the same array of services has not worked several times, is it sensible to provide the same services and expect a different outcome or ethical to abandon such clients by refusing further services?

It is important when running any business to understand why the services we provide do not adequately meet our customers' needs. In the addictions field, we need to understand why so many clients drop out of treatment early and/or continue to relapse. The problems may be logistical (e.g., a lack of transportation, childcare), social (e.g., a partner, social peers), or due to a lack of linkage to a community that supports recovery. In our follow-up interviews, we have been struck by the number of relapsed clients who experienced their requests for further help as a shaming ritual and who were often refused re-admission on the grounds that they would be taking a bed from someone who was more deserving or told that the program had nothing new to offer them. Disrespect (e.g., castigation as "retreads" or "frequent flyers") and abandonment seem to be the norm for clients with chronic addiction problems. It is ironic that the treatment system is least welcoming to those who need its services the most. We need a new approach for clients whose problems are marked by high severity and chronicity.

Utilize ongoing monitoring and early re-intervention to prevent and/or shorten the length of major episodes of relapse. Ongoing management of other chronic health conditions successfully controls the severity and progression of these conditions when such conditions cannot be cured. A core assumption underlying this approach is that long-term monitoring through regular checkups and early re-intervention facilitate early detection of relapse, reduce the time to treatment reentry and consequently improve long-term participant outcomes. This approach also does not rely on participants to self-identify their symptoms and return to treatment. Recovery checkups are pro-active and include quarterly assessments and personalized feedback for each

participant on the status of their condition. The clients we have interviewed for years often describe the value of these checkups in terms of empathy and acceptance, kindness and courtesy, belief in the client's capacity to change, respect for the client's right to learn from good and bad choices, linkage to crucial resources, and simply hanging in through the client's setbacks and successes.

Provide multiple avenues in addition to traditional treatment. There is growing evidence that the processes of recovery maintenance are different than the processes of recovery initiation (White & Kurtz, in press). While treatment as currently designed can be a boon to recovery initiation, it offers little support for long-term recovery maintenance for those with the most severe problems. Many returning clients need only the briefest of treatments to re-achieve biopsychosocial stabilization, but they often need a broad range of non-clinical recovery support services to sustain recovery over time. As models of recovery management emerge, treatment agencies will develop larger service menus and will collaborate with a much larger spectrum of community agencies in helping people both get sober and stay sober. Such resources will include the growing diversity of recovery mutual aid societies, the rapidly expanding network of recovery homes, new recovery support organizations (e.g., recovery support centers, faith-based recovery ministries, recovery schools, recovery work co-ops) and roles (e.g., recovery coaches).

One of the contributions of longitudinal studies is a clearer picture of the course of addiction and the affirmation of the potential for recovery even among those clients whose addictions are characterized by great severity, chronicity, and the need for multiple episodes of treatment. We have been humbled and inspired by the stories we have collected and hope you will benefit from the understandings we have tried to extract from these stories. The traditional concepts of "discharge" followed by brief "aftercare" have less meaning in the shift from acute care to recovery management models. To quote Dr. J. H. Kain (1828, p. 295), "Chronic diseases require chronic cures." His adage suggests the need to remain involved with clients to help them manage the prolonged course of both addiction and recovery.

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# RECOVERY MANAGEMENT

**William L. White, MA**
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# Front Cover (back page)

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# Preface

*Dear Colleague,*

*The Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC) is part of a national network that includes 14 regional centers and a national office, funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. Great Lakes' primary goal is to help elevate the quality of addiction treatment by designing and delivering culturally competent, research-based training, education, and systems-change programs for addiction treatment and other allied health professionals. Great Lakes ATTC is very pleased to be able to offer its professional constituents a new monograph on the topic of Recovery Management.*

*Many of the central ideas contained in this monograph were birthed over the past eight years inside the Behavioral Health Recovery Management project — a joint venture by Fayette Companies in Peoria, Illinois and Chestnut Health Systems in Bloomington, Ilinois. Many of the core strategies outlined in this monograph have been and are being tested within the Lighthouse Institute (Chestnut Health Systems' research division) and within other addiction research centers around the country.*

*This monograph contains a synthesis of findings from scientific studies and recommendations from new grassroots recovery advocacy and support organizations that are collectively pushing a fundamental redesign of addiction treatment in the United States. Based on growing evidence of the chronicity and complexity of severe substance use disorders, we are faced with an increasing need to shift the current acute care model of treatment toward a model of assertive and sustained recovery management.*

*This monograph introduces the recovery management model through a collection of four papers.*

- *The first paper, entitled "Recovery: The New Frontier," describes the historical shift in the addictions field from a pathology paradigm (knowledge derived from studies of the problem), through an intervention paradigm (knowledge derived from the clinical treatment of the problem), to an emerging recovery paradigm (knowledge derived from individuals, families, and communities that have solved the problem). It concludes with a discussion of ways in which this latter paradigm will reshape the future of treatment and recovery in the United States.*
- *The second paper, "The Varieties of Recovery Experience," describes what we as a country know from the standpoint of science and cultural experience about the long-term resolution of alcohol and other drug problems, as well as the implications of this knowledge for the design of addiction treatment.*
- *The third paper, "Recovery Management: What if we really believed addiction was a chronic disorder?" defines the core principles, changes in clinical practices, implementation obstacles, and potential pitfalls of the recovery management model.*
- *The final paper, "Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities," describes the special advantages the recovery management model offers to communities of color in the United States.*

*Special thanks are due to Fayette Companies and Chestnut Health Systems, whose early pioneering work laid the foundation for this monograph; to the authors — William White, Ernest Kurtz, and Mark Sanders — for their work on these papers; and to the many addiction professionals in the states of Illinois, Indiana, Michigan, Ohio, and Wisconsin whose input in workshops over the past several years helped refine many of the ideas in these pages. Special gratitude is also extended to Herminio Rodriguez, whose brilliant and creative design and production work brought this publication to life; and to Pamela Woll, author and Great Lakes partner, who lent her magical "eyes" to the copy editing of this document.*

*Great Lakes ATTC is offering this monograph, not as the last word on this subject, but as a catalyst for renewed discussion about the future of addiction treatment and recovery in America. We invite you to be an active voice in these discussions. Recovery management is an idea whose time has come. It will be up to addiction treatment professionals and recovery support specialists across the country to bring that idea to life within the individuals, families, and communities we are committed to serve. The journey toward that goal will require courage and sustained commitment. Great Lakes ATTC and its staff look forward to sharing that journey with you.*

*Lonnetta Albright*
*Director*
*Great Lakes ATTC*

# Recovery Management

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# Recovery: The Next Frontier

*William L. White, MA*

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

## The Pathology Paradigm

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

## The Intervention Paradigm

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

know a lot about what people look like in the years before they were admitted to treatment. We know a lot about what people look like during treatment. And we know a little bit about what people look like in the months following treatment.

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

### Agitation for Change

For readers who think they and their programs and the larger field are already recovery-focused, it may be helpful to view this issue through the eyes of the recovery advocates (of the 1950s-1960s) who were the midwives of modern addiction treatment. It is among these advocates that the need and call for this recovery paradigm is most poignantly articulated. The advocacy leaders in local alcoholism and "drug abuse" councils were inspired by a vision of an ever-expanding recovery community. They championed the birth of professionally directed treatment as a special doorway of entry into that community for the many people who could not make the transition from addiction to recovery on their own. Decades later, these advocates see an ever-growing treatment industry that views recovery as an afterthought or adjunct to itself. While this view may seem harsh to the reader, consider the world through the advocates' eyes. They see "addiction studies" curricula in colleges and universities but no "recovery studies" curricula. They see scientific journals whose names reflect an interest in alcohol and other drugs (e.g., *Journal of Studies on Alcohol, Journal of Psychoactive Drugs, Addiction, Contemporary Drug Problems*) and professional intervention into AOD problems (e.g., *Journal of Substance Abuse Treatment, Alcoholism Treatment Quarterly*), but they see no peer-reviewed journals focused on the scientific study of addiction recovery. They read innumerable studies that meticulously describe who uses which psychoactive drugs and with what consequences, but see only a few recovery prevalence studies. They confront the public perception that people do not recover despite rarely acknowledged epidemiological studies finding that 58% of people with lifetime substance dependence eventually achieve sustained recovery (Kessler, 1994; see also Dawson, 1996; Robins & Regier, 1991). They see national institutes of "alcohol abuse and alcoholism" and "drug abuse" and national centers of "substance abuse prevention" and "substance abuse treatment" but they see no "national institute/center of addiction recovery." They see "addiction technology transfer centers" but no "recovery technology transfer centers." In short, they see a field that knows a lot

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

## The Recovery Paradigm

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

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

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

## Recovery Management

How will the transition toward a recovery-focused future differ from our past? The shift

from acute intervention to recovery management for those persons with severe and persistent AOD problems will involve three changes in the continuum of care. First, it will intensify pre-treatment recovery support services to strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, and determine whether the individual/family can initiate and sustain recovery at this stage without additional professional intervention. (The latter may be quite possible for those with lower problem severity and indigenous supports for recovery.) Second, recovery management will intensify in-treatment recovery support services to enhance treatment retention and effects (by keeping treatment recovery focused). Traditional treatment methods will change in a number of important dimensions (e.g., from single-agency to multi-agency intervention, from categorical to global assessment, from institution-based to neighborhood- and home-based service delivery). Most important, it will differ in the nature and duration of the service relationship. Third, recovery management will shift the focus of treatment from acute stabilization to support for long-term recovery maintenance. Professionally directed recovery management, like management of other chronic health disorders, shifts the focus of care from one of "admit, treat, and discharge" to a sustained health management partnership. This means that the traditional discharge process will be replaced with post-stabilization monitoring (recovery check-ups); stage-appropriate recovery education; recovery coaching; active linkage to communities of recovery; recovery community resource development; and, when needed, early re-intervention. Rather than cycling individuals through multiple self-contained episodes of acute treatment, recovery management provides an expanded array of recovery support services for a much greater length of time but at a much lower level of intensity and cost per service episode.

## A New Language

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

- delineate the conceptual boundaries of *recovery;*
- describe types of recovery, e.g., partial versus full, serial recovery, solo versus assisted, medication-assisted recovery;
- evaluate recovery assets, e.g., Granfield and Cloud's (1999) concept of "recovery capital";
- chart the pathways of recovery, e.g., secular, spiritual, religious;
- distinguish styles of recovery initiation, e.g., incremental versus transformational change;
- depict variations in identity reconstruction, e.g., recovery-positive versus recovery-neutral identities; and
- describe variations in recovery relationships (with other recovering people, e.g.,

acultural, bicultural, and culturally enmeshed styles) (see White, 2002 for a detailed discussion of this new language).

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

## A New Vision

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

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# The Varieties of Recovery Experience:

## A Primer for Addiction Treatment Professionals and Recovery Advocates

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**Abstract**

*The study of alcohol and other drugs (AOD) is historically marked by three stages: 1) the investigation of AOD-related social and personal pathologies, 2) the development of personal and social interventions aimed at resolving AOD problems, and 3) a focus on the prevalence and patterns of long-term recovery from AOD problems. This essay honors this transition from addiction and treatment paradigms to a recovery paradigm by exploring the growing varieties of pathways and styles through which people are resolving serious and persistent AOD-related problems. A review of scientific and mutual aid literature is used to catalogue variations in:*

- *scope of recovery (primary and secondary chemical health and global health),*
- *depth of recovery (partial, full, and enriched),*
- *types of recovery (abstinence-based, moderation based, medication assisted),*
- *context of recovery initiation (solo, peer assisted, treatment assisted),*
- *frameworks of recovery initiation (religious, spiritual, secular),*
- *temporal styles of recovery initiation (transformative change, incremental change, drift),*
- *recovery identity (positive, neutral, negative),*
- *recovery relationships (acultural, bicultural, and enmeshed styles; virtual recovery),*
- *recovery stability/durability (At what point does present remission predict future remission?), and*
- *recovery termination (Is recovery ever completed?).*

*After exploring the wide diversity of recovery styles and experiences that exist within Twelve-Step fellowships and other recovery mutual aid societies, the article explores the implications of the wide diversity in recovery experiences to the design and conduct of addiction treatment.*

**Keywords:** addiction recovery, natural recovery, transformative change, stages of change, virtual recovery, religion, spirituality, secularity.

## Addiction, Treatment, and Recovery Paradigms

Alcohol- and other drug-related (AOD) problems constitute a significant public health problem within American and world history (Lender & Martin, 1982; Musto, 1999; Courtwright, 2001). Responses to these problems over the past two centuries reflect three organizing paradigms. From the late eighteenth century through the era of alcohol prohibition, pathology provided an organizing framework, whether religiously or medically conceived. The pathology paradigm fueled the debate over whether alcoholism was a sin or a sickness; guided studies of the incidence, prevalence and personal/social costs of AOD problems; and sparked the sustained search for the etiological roots of these problems. The hope upon which the pathology model was built was that knowledge of the scope and sources of AOD problems would generate specific solutions to these problems in the same way isolating and attacking particular pathogens had earlier led to the elimination or control of many infectious diseases. While failing to achieve this ultimate goal to-date, the pathology model has made significant contributions to our understanding of the multidimensional processes that interact to initiate and sustain addiction.

The failure to find the singular pathogen underlying AOD problems led to the testing of numerous strategies and techniques of intervention, both social and personal. To this day, the intervention model buttresses multi-billion-dollar industries aimed at preventing drug use, controlling drug supplies, punishing drug offenders, and treating those with severe AOD problems. The intervention model assumes that the scientific evaluation of AOD-related social policies and biopsychosocial interventions will reveal the most effective prevention, intervention, and control strategies, and that those strategies that can be best matched to particular communities, demographic/clinical subpopulations, and individuals. This model has generated significant new understandings that are sparking widespread calls to bridge the gap between clinical research and clinical practice in addiction treatment.

The historical intractability of AOD problems at a societal level has led to disillusionment with the pathology and intervention paradigms and a recent shift in focus toward resilience and recovery (Morgan, 1995a; Elise, 1999; White, 2000, 2004a). As early as 1984, Edwards was calling for the field to explore the “natural processes of recovery.” This was followed by calls for “recovery-oriented psychotherapy” (Zweben, 1986) and “recovery-sensitive counseling” (Morgan, 1995b). The recovery paradigm focuses on at-risk individuals, families, and communities who have avoided the development of severe AOD problems and the lives of individuals, families, and communities with severe AOD problems who have successfully resolved or are resolving these problems. Advocates of this model suggest that studying the lived solutions to AOD problems will reveal principles and strategies upon which broader, more effective social policies and professional interventions can be built (Morgan, 1995a; White, 2005).

Knowledge about AOD problems is substantial, but comparatively little is known from the standpoint of science about the long-term solutions to these problems. In recent epidemiological studies of individuals who once met criteria for alcohol dependence, 63% to 75% no longer met dependence criteria at the time they were surveyed, suggesting a

substantial long-term recovery rate (Helzer, Burnam, & McEvoy, 1991; Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). The Workgroup on Substance Abuse Self-help Organizations (2003) estimates the total U.S. membership of recovery mutual aid groups at more than 1.6 million people and reports that more than six million adults each year have some contact with these groups. In spite of a substantial body of recovery experience in the U.S., the addictions field does not draw its primary knowledge base from this source. Today, addiction professionals routinely assert the existence of multiple pathways of recovery, but from the standpoint of science, we know little about such pathways. As addiction treatment interventions become ever briefer, treatment professionals have less and less contact and knowledge of the long-term recovery process.

AOD problems arise out of quite different personal, family, and cultural contexts and unfold in variable patterns and trajectories. These same forces generate heterogeneous recovery experiences. The goals of this paper are to: 1) conceptually map the diverse patterns and styles of AOD problem resolution, 2) introduce a lexicon through which such variations can be described, and 3) explore the implications of the diversity of recovery experience for the design and conduct of professional interventions into such problems. This conceptual map is based primarily on scientific studies on the course of AOD problems in community and in clinical samples. The literature of multiple recovery mutual aid societies and biographical and autobiographical depictions of recovery are also used to illustrate key findings. We hope this preliminary recovery map will spark new scientific studies of the prevalence, patterns, stages, and personal styles of long-term recovery from AOD problems.

## Recovery Definition

*Recovery* is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for *substance abuse* or *substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational, and occupational health.

AOD problems vary in their course, including adverse reactions to a single episode of AOD-intoxication, problems that span only a few months or years, and problems that span significant periods of one's life. Such problems also vary in their intensity and overall severity, including:

- subclinical problems (transient AOD problems that do not meet DSM-IV criteria for abuse or dependence);

- AOD problems meeting DSM-IV criteria for substance abuse — Clinically significant impairment marked by one or more of the following in a 12-month time period: repeated substance use that results in failure to perform major role obligations, repeated use in situations that are physically hazardous, repeated substance-related legal problems, and continued substance use in spite of adverse AOD-related problems; and

- AOD problems meeting DSM-IV criteria for substance dependence — Clinically

> significant impairment marked by at least three of the following in a 12-month period: tolerance, withdrawal, loss of control (erosion of volitional control over quantity and duration of use), failed efforts to cease or reduce use; significant time involved in drug procurement, drug use, and recovery from drug effects; social, occupational, or recreational activities forsaken or reduced due to drug use; and continued use in spite of adverse physical or psychological problems caused by substance use (American Psychiatric Association, 1994).

The term *recovery*, because of its medical connotations, is most applicable to the process through which severe and persistent AOD problems (meeting DSM-IV criteria for substance abuse or dependence) are resolved. Terms such as *quitting*, *cessation,* and *resolution* more aptly describe the problem-solving processes of individuals who have transient and less severe AOD problems. Recovery implies reversal of a greater level of debility and a more involved and enduring problem-solving process (White & Scott, draft manuscript). Our continued discussion of varieties of recovery experience will focus on these more severe forms of AOD problems.

The term *family recovery* conveys the processes through which family members impacted by severe and persistent AOD problems individually and collectively regain their health. Family recovery involves enhanced health across three dimensions: 1) individual family members, 2) family subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships), and 3) the family as a system (redefinition of family roles, rules, and rituals; recovery-conducive boundary transactions with people and institutions outside the family) (White, 1996). The recovery of an addicted family member can destabilize and threaten the survival of the family unit if professional and social supports are not available to soften what Stephanie Brown and Virginia Lewis (1999) have christened the "trauma of recovery" (See also Rouhbakhsh, Lewis, & Allen-Byrd, 2004).

### Recovery Prevalence

Elaborate systems exist to measure the subtlest of changes in the prevalence of AOD use and its consequences, but no similar system exists to measure the incidence and prevalence of recovery from AOD problems. However, individual researchers have conducted long-term treatment follow-up studies and community surveys over the past 25 years that reveal significant recovery rates: 41% (Ojesjo, 1981); 63% (Helzer, Burnam & McEvoy, 1991); 72% (Dawson, 1996); 30% (Schutte, Nichols, Brennan, & Moos, 2001); 59% (Vaillant, 2003); and 48% (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Factors such as differing demographic and clinical characteristics of study participants and different definitions of recovery influence variations in reported recovery rates.

### The Scope and Depth of Recovery

Recoveries from addiction can differ in their scope (the range of measurable changes) and depth (degree of change within each measured dimension). Aborting a destructive relationship with a particular drug or combination of drugs is at the core of addiction recovery, but recovery experiences can range from complete cessation of AOD use in an otherwise unchanged life to a complete transformation of one's personal identity and

interpersonal relationships.

There are quite varied trajectories in the relationship between primary and secondary drug use among people seeking recovery from substance use disorders. One pattern of drug dependence can be aborted while a co-occurring pattern continues. For example, there are high rates of nicotine dependence among adults and adolescents before and after treatment for dependence upon alcohol, opiates, cocaine, and cannabis (Maddux & Desmond, 1986; Myers & Brown, 1990; Hughes, 1995, 1996; Bien & Barge, 1990; Hoffman & Slade, 1993).

A second pattern involves the escalation of secondary drug use following cessation of primary drug use, e.g., an increase in alcohol or cocaine use following the cessation of heroin use. Such drug substitution is a common problem in treated adults and adolescents, particularly among those with a history of polydrug use (Vaillant, 1979; Edwards, Duckitt, Oppenheimer, Sheehan, & Taylor, 1983; Toneatto, Sobell, Sobell, & Rubel, 1999; Maddux & Desmond, 1980, 1981, 1992; Anglin, Almong, Fisher & Peters, 1989; Simpson & Sells, 1990; Carmelli & Swan, 1993).

A third pattern involves individuals who use secondary drugs therapeutically during early recovery to manage acute and post-acute withdrawal and to help ameliorate the psychological stresses of early recovery (e.g., heroin users consuming cannabis following opiate abstinence to prevent relapse) (Willie, 1978; Waldorf, 1983; Biernacki, 1986; Copeland, 1988). In this pattern, secondary drug use ceases or decelerates within the first two years of recovery (Waldorf, 1983; Vaillant, 1979; Copeland, 1988; Bachus, Strang, & Watson, 2000).

The ability to understand when drug substitution is an effective, time-limited strategy for managing early recovery (requiring professional understanding, if not tolerance) and when drug substitution is a mutation of the existing problem (requiring prevention, early intervention, or focused treatment) is an important research agenda. Some investigators have found that secondary drug use is more likely to be problematic for persons with family histories of AOD problems, those who begin AOD use at an early age, and those who experience problems with a secondary drug before developing their primary addiction (Simpson & Sells, 1990; Maddux & Desmond, 1992). Also needed is a greater understanding of how sequential drug problems are resolved over time. The factors that contribute to the cessation of co-occurring dependencies or secondary drug use may differ from those factors associated with the cessation of primary drug use (Downey, Rosengren, & Donovan, 2000).

The scope of recovery can extend far beyond altered patterns of primary and secondary drug use. Historically, the definition of recovery has shifted from a focus on what is deleted from one's life (alcohol and other drugs, arrests for criminal acts, hospitalizations) to what is added to one's life (the achievement of health and happiness). This shift is reflected in such terms as *mental sobriety* (Mental Sobriety, 1946) and *emotional sobriety* — a phrase A.A. co-founder Bill Wilson coined to describe a state of emotional health that far exceeds the achievement of not drinking. Wilson defined emotional sobriety as "real maturity . . . in our relations with ourselves, with our fellows and with God" (Wilson, 1958). This broadened vision of recovery is also reflected in the term *Wellbriety* that is currently

being used within the Native American recovery advocacy movement to depict recovery as the pursuit and achievement of physical, emotional, intellectual, relational, and spiritual health, or "whole health" (Coyhis, 1999; *Red Road to Wellbriety*, 2002). Wellbriety within the Native American context is also related to a new set of core *recovery values*: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

Because severe and persistent AOD problems impact many areas of life functioning, recovery from such problems must be measured across multiple *zones* (or *domains*) *of recovery*: 1) the relationship(s) with the substance(s) for which one previously met DSM-IV criteria for abuse or dependence; 2) the presence, frequency, quantity, intensity, and personal and social consequences of secondary drug use; 3) physical health; 4) psychological/emotional/ontological health; 5) family/relational health; and 6) lifestyle health, e.g., a developmentally appropriate, pro-social style of work and leisure (White, 1996). Seen as a whole, the goal of recovery is what we refer to as *global health*.

Like that of other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of *full recovery* (complete and enduring cessation of all AOD-related problems and the movement toward global health) or a state of *partial recovery* (Jorquez, 1983). The term *partial recovery* can convey two different conditions: 1) a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems; or 2) the achievement of complete abstinence or stable moderation, but the failure to achieve parallel gains in physical, emotional, ontological, relational, or occupational health. Partial recovery can constitute a permanent state, a stage preceding full recovery, or a hiatus in AOD problems with eventual reversion to a previous or greater level of problem severity.

Falling between the parameters of no recovery and full recovery are individuals who cycle in and out of periods of moderate use, problematic use, and abstinence (Hser, Hoffman, Grella, & Anglin, 2001). A recent review of alcoholism treatment outcome studies drew three major conclusions: 1) treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third of those treated, 2) substance use (measured by days of use and volume of use) decreases by an average of 87% following treatment, and 3) substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). People who are constitutionally incapable of permanent sobriety at particular points in their lives may achieve *partial recovery* — significant decreases in AOD-related problems, improved levels of health and social functioning, and significant reductions in the costs and threats they pose to the larger community (Zweben 1996).

Partial recovery is reflected in individuals who cycle through multiple episodes of treatment, recovery initiation, and relapse (Scott, Foss & Dennis, 2005; Dennis, Scott, Funk & Foss, 2005). Such cycling is evidence that recovery is not fully stabilized, but the continued help seeking within such cycles also suggests that addiction is no longer stable. Cycling in and out of recovery (with reduced frequency, intensity, and duration of use episodes) can be a precursor to stable recovery or a chronic state.
Partial recovery can also refer to residual levels of impairment that continue after the ces-

sation or deceleration of AOD use. While most recovering alcoholics establish levels of personal and family functioning comparable to non-alcoholics (Moos, Finney, & Cronkite, 1990; Chapman, 1987), early recovery can be marked by poor levels of adjustment, e.g., depression, anxiety, poor self-esteem, guilt, and impaired social functioning (Kurtines, Ball, & Wood, 1978; Polich, Armor, & Braiker, 1980; Gerard & Saenger, 1962; Behar, Winokur, & Berg, 1984). De Soto and colleagues (1985) distinguished recovery status by length of recovery in a study of 312 members of Alcoholics Anonymous. They concluded that: 1) the early months and years of recovery from alcoholism are marked by continued impairment of emotional and social functioning, 2) these symptoms continue to improve and remit over the first ten years of recovery, and 3) some residual symptoms of cognitive dysfunction may continue in long-term recovery. The achievement of only a partial reversal of alcohol-related cognitive impairments is most common in alcoholics who began their recoveries after long drinking careers (Goldman, 1983; Schutte, 1994, 2001). The principle that global health and functioning improve with earlier onset of recovery and length of sobriety is further confirmed in follow-up studies of persons recovering from cocaine addiction (Selby, Quiroga, Ireland, Malow, & Azrin, 1995).

Some individuals experience changes so profound across these zones of recovery that they come to view addiction and recovery as "gifts" that have brought a depth of experience and meaning far superior to their pre-addiction lives. Such individuals achieve an enriched *state of recovery*. This enriched state of recovery is evident across recovery traditions:

> *The walls crumpled — and the light streamed in. I wasn't trapped. I wasn't helpless. I was free, and I didn't have to drink to "show them." This wasn't "religion" — this was freedom! Freedom from anger and fear, freedom to know happiness and love.* (From *Alcoholics Anonymous*, 1976, p. 228.)

> *It is impossible to put on paper all the benefits I have derived . . . physical, mental, domestic, spiritual, and monetary. This is no idle talk. It is the truth. (*From *Alcoholics Anonymous*, 1976, p. 481.)

> *My life is well-rounded and I am becoming a more comfortable version of myself, not the neurotic, boring person that I thought I would be without drugs…..I have a way to live cleanly, honestly and comfortably. I have all I need.* (From *Narcotics Anonymous*, 1988, p. 262.)

> *It's been a very long, long struggle but worth every single minute of it. I'm really happy to be alive, and life is truly great and wonderful for me right now.* (Women for Sobriety member, From Kirkpatrick, 1986, p. 258.)

> *Back in 1970 I found myself dying from the abuse of my body….The Creator had something he had for me to learn. First, I had to learn who he was. Then I had to learn who I was. I began to visit with my Elders….I had to come to grips with who I am as an Indian, as being a castaway, as being an unloved person. The Creator has love for each of us but we have to find that foundation.* (From *Red Road to Wellbriety*, 2002, p. 187.)

A final scope-and-depth dimension of recovery involves individuals who are engaged in concurrent or sequential recovery processes from two or more conditions or experiences, e.g., developmental trauma, psychiatric illness, AIDS. The overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders might be described as *serial recovery*.

### Problem Severity and Recovery Capital

Recovery can occur at different stages of problem progression. There are patterns of *high-bottom recovery* among people who have not yet suffered severe losses related to their AOD use. There are also patterns of *low-bottom recovery* achieved by individuals in the latest stages of addiction who have experienced severe personal and social disintegration and anguish before achieving stable recovery (High Bottom, 1949).

In addition to the degree of problem severity, one's recovery capital influences one's prognosis for recovery. *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). The interaction of problem severity and recovery capital shapes both the prospects of recovery and the intensity and duration of resources required to initiate and sustain recovery.

### Pathways and Styles of Recovery

The phrase *pathways of recovery* refers to different routes of recovery initiation. This phrase recognizes the varieties of ways people successfully resolve AOD problems. One of the earliest origins of this notion of paths and choices of recovery frameworks was A.A. co-founder Bill Wilson's 1944 observation that "The roads to recovery are many" (Wilson, 1944). *Cultural pathways of recovery* are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. Such culturally prescribed avenues might be a product of:

- developmental consciousness (e.g., something to be resolved through maturation and assumption of adult role responsibilities),
- medical consciousness (e.g., response to an alcohol-related health problem),
- religious consciousness (e.g., conversion to and/or affiliation with an abstinence-based faith community), or
- political consciousness (e.g., rejection of alcohol as a "tool of genocide").

The phrase *styles of recovery* depicts variations in beliefs and recovery support rituals that exist within particular pathways of recovery. For example, Twelve-Step programs constitute one of the major pathways of recovery from addiction, but the close observation of several Twelve-Step groups would reveal wide variation in styles of "working the program," e.g., patterns of meeting attendance, approaches to "Step work," conceptual-

izations of “Higher Power,” and utilization of sponsors.

### Abstinence-based, Moderation-based, & Medication-supported Recoveries

One of the variations in recovery from substance use disorders involves differences in the ways in which one’s relationship with psychoactive drugs is changed. The scientific literature on the resolution of AOD problems documents three such variations. *Abstinence-based recovery* has historically been the culturally prescribed approach to the resolution of severe AOD problems. This approach, which has guided mainstream addiction treatment in the United States in the modern era, calls for complete and sustained cessation of one’s primary drug(s) and the non-medical use of other psychoactive drugs (with nicotine and caffeine historically excepted). Over the past several decades, scientific evidence has grown on moderated approaches to AOD problem resolution. *Moderation-based recovery* (the sustained deceleration of AOD use to a subclinical level — continued AOD use that no longer meets DSM-IV criteria for substance abuse or dependence) has triggered great debates in America, spanning the 1976 Rand Report[1], the extended controversies over Mark and Linda Sobell’s research at Patton State Hospital[2], and later controversies surrounding Moderation Management, a moderation-based mutual support group (Kishline, 1994). There has also been growing interest in *medication-assisted recovery* (the use of medically monitored pharmacological adjuncts to support recovery from addiction, e.g., detoxification agents, stabilizing agents, aversive agents, antagonizing agents, anti-craving agents, or psychoactive drugs prescribed for the treatment of co-occurring physical or psychiatric disorders).

Discussion of these approaches is best grounded in the finding that substance-use problems exist across a continuum of problem severity and that problem severity influences pathways of problem resolution. Abstinence-based and medication-assisted styles of recovery predominate in patterns of severe alcohol and drug dependence, whereas moderation-based styles of recovery predominate in individuals with lower problem severity and greater recovery capital (younger, married, employed, higher socioeconomic status, higher social support and social stability, positive marital and work relationships) (Finney & Moos, 1981; Polich, et al., 1980; Vaillant, 1983; Armor & Meshkoff, 1983; Edwards et al., 1983; Rosenberg, 1993; Dawson, 1996; Cunningham, Lin, Ross, & Walsh, 2000; Vaillant, 1996).

The moderated resolution of substance use disorders is well documented in general population surveys. Dawson (1996), in a community survey of treated and untreated adults who previously met DSM-IV criteria for alcohol dependence, found that in the year prior to the survey 49.9% were drinking but no longer met criteria for abuse or depen-

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[1] The initial Rand Report included the finding: “...it appears that some alcoholics do return to normal drinking with no greater likelihood of relapse than alcoholics who choose abstention...” (Quoted in White, 1998). Controversies surrounding this report led to a second report that softened the initial report’s findings.

[2] Drs. Mark and Linda Sobell published a series of scientific reports documenting that some alcoholics achieve controlled drinking (Sobell and Sobell, 1973, 1976, 1978). These reports were followed by a re-evaluation by Pendery, Maltzman, and West (1982) that challenged the Sobell’s findings and their professional integrity. The Sobell weathered blistering personal and professional attacks in spite of being later cleared of wrongdoing by two separate scientific panels (Dickens, Doob, Warwick, & Winegard, 1982; Trachtenberg, 1984)

dence (27.8% met criteria for alcohol abuse or dependence, and 22.3% were abstinent). Two other studies (one a Canadian national study and the other an Ontario study) used a broader definition of "alcohol problems" and found that 38% and 62.7% (respectively) of those with alcohol problems had later resolved those problems via moderate drinking recoveries (Sobell, Cunningham, & Sobell, 1996). Moderated recovery at much lower rates of prevalence has also been noted in follow-up studies of those treated for alcohol dependence (Finney & Moos, 1981; Rosenberg, 1993; Vaillant 1996) and drug dependence (Levy, 1972; Willie, 1978; Harding, Zinberg, Stelmack, & Michael, 1980). Treatment outcome studies of adolescents have also found a subgroup of treated teens who "may evidence intermittent substance use, typically alcohol, but do not exhibit any ongoing alcohol-or-drug-related problems" (Brown, 1993).

Given the propensity for substance-related problems to wax and wane over time, one could rightly question whether subclinical use following addiction is sustainable. In the longest follow-up study of alcoholic men to-date (60 years), Vaillant (2003) found that 4% of inner-city men and 11% of college men sustained controlled drinking over the course of the follow-up. Most migrated from dependence to efforts at control to eventual abstinence. In the largest and most recent alcohol dependence and recovery prevalence survey (recovery defined as meeting DSM-IV alcohol dependence criteria prior to the last year but not meeting these criteria during the past year), 25% of those with prior alcohol dependence continued to meet dependence criteria, 27% were in partial remission (subclinical symptoms of dependence or presence of alcohol abuse), 12% were asymptomatic risk drinkers (drinking in a pattern predictive of risk for future relapse), 18% were low-risk drinkers, and 18% were abstainers (Dawson et al., 2005). As problem severity declines, the prevalence of moderated outcomes increases. This is most frequently noted in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood but later moderate their substance use (Fillmore, Hartka, Johnstone, Speiglman, & Temple, 1988).

Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting that moderation was an option for some problem drinkers, but not for "alcoholics" like themselves. The following two excerpts reflect their beliefs and attitudes about moderation-based recovery.

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason — ill health, falling in love, change of environment, or the warning of a doctor — becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention* (*Alcoholics Anonymous*, 1939, p. 31).
>
> *If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people!* (*Alcoholics Anonymous*,1939, p. 42).

Medication-assisted recovery continues to generate considerable controversy within the

American culture, within communities of recovery, and within the professional addiction treatment community, in spite of evidence that attitudes toward medications as an adjunct to recovery may be softening (Rychtarik, Connors, Demen, & Stasiewicz, 2000). Influencing these shifts in attitudes are new pharmacological adjuncts in the treatment of alcohol dependence (e.g., naltrexone, acamprosate) and opiate dependence (e.g., clonidine, buprenorphine) (Vopicelli & Szalavitz, 2000).

One of the most widespread approaches to medication-assisted recovery is methadone maintenance treatment (MMT). There are an estimated 900,000 narcotic addicts in the United States and approximately 179,000 individuals enrolled in MMT (Kreek & Vocci, 2002). The major health policy authorities in the United States have weighed in on MMT and have universally concluded that optimal dosages of methadone combined with psychosocial supports and administered by competent practitioners: 1) decrease death rates of opiate addicts by as much as 50%; 2) reduce transmission of HIV, hepatitis B, hepatitis C and other infections; 3) eliminate or reduce illicit opiate use; 4) reduce criminal activity; 5) enhance productive behavior via employment and academic/vocational functioning; 6) improve global health and social functioning; and 7) are cost-effective (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998; White & Coon, 2003). In spite of such evidence, misunderstanding and social stigma attached to MMT (the perception that MMT simply substitutes one addictive drug for another) leave many in methadone-assisted recovery hiding their recovery status and stories from their employers and co-workers, their friends, and even their own family members (Murphy & Irwin, 1992).

### The Context of Recovery Initiation

The context in which people achieve remission from substance use disorders varies considerably and includes styles of solo recovery, treatment-assisted recovery, and peer-assisted recovery.

*Solo (natural) recovery* involves the use of one's own intrapersonal and interpersonal resources (family, kinship, and social networks) to resolve AOD problems without benefit of professional treatment or involvement in a recovery mutual aid community. This phenomenon is extensively documented in the professional literature under such descriptors as *maturing out* (Winick, 1962, 1964), *autoremission* (Vaillant, 1983; Klingeman, 1992), *self-initiated change* (Biernacki, 1986), *unassisted change* (McMurran, 1994), *spontaneous remission* (Tuchfield, 1981; Anthony & Helzer, 1991), *de-addiction* (Frykholm, 1985; Klingeman, 1991), *self-change* (Sobell, Sobell, & Toneatto, 1991), *self-managed change* (Copeland, 1988), and *natural recovery* (Havassey, Hall, & Wasserman, 1991). Natural recovery is, according to some studies, the most common recovery pathway (Fillmore, et al., 1988; Sobell, Sobell, Toneatto, & Leo, 1993; Cunningham, Sobell, Sobell, & Kapur, 1995; Cunningham, 1999; Sobell, et al., 1996), but the prevalence of this style declines as problem duration and severity increase. Natural recovery is a more viable pathway for people with shorter and less severe AOD problems and for those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell, et al., 1996; Larimer & Kilmer, 2000).

Natural recovery exists across the spectrum of drug choices (Biernacki, 1986; Waldorf, Reinarman, & Murphy, 1991; Klingeman, 1992; Shaffer & Jones, 1989; Cohen & Sas, 1994; Toneatto et al., 1999; Kandel & Raveis, 1989) and seems to be influenced by two age-related patterns: 1) a young adult pattern associated with maturation and the assumption of adult role responsibilities, and 2) a later-life pattern associated with cumulative consequences of alcohol and other drug use (Fillmore, et al., 1988; Sobell, Ellingstad, & Sobell, 2000).

Those who achieve natural recovery report multiple reasons for avoiding formal treatment institutions and mutual aid societies. These reasons include a desire to protect their privacy (aversion to sharing problems with others), a desire to avoid the stigma of being labeled, a belief that they can solve their problems without professional treatment, and a perception that treatment and mutual aid groups are ineffective or not personally suited for them (Tuchfield, 1981; Jordan & Oei, 1989; Cloud & Granfield, 1994; Burnam, 1997; Sobell, Ellinstad, & Sobell, 2000).

*Treatment-assisted recovery* involves the use of professional help in the initiation and stabilization of recovery. More than 1.5 million people are admitted to addiction treatment in the United States each year, but multiple factors complicate the relationship between treatment and recovery:

- Less than 10% of people with a substance use disorder in the U.S. seek professional treatment in a given year (SAMHSA, 2003), and only 25% of individuals with such disorders will receive treatment in their lifetime (Dawson et al., 2005).

- Addiction treatment in the United States is not a homogenous entity, but a network of service organizations with diverse philosophies and techniques that vary significantly in their effectiveness (Wilbourne & Miller, 2003).

- Those who seek professional treatment are characterized by high personal vulnerability (e.g., family history of AOD problems, lowered age of onset of use, traumatic victimization), greater problem severity and complexity, weaker social supports, fewer occupational opportunities, and less success (Polich, Armour, & Braiker, 1980; Room, 1989; Weisner, 1993; Tucker & Gladsjo, 1993; Cunningham et al., 1995).

- Recovery outcomes are compromised by high treatment attrition rates (more than 50%) (SAMHSA, 2002) and doses of treatment services (measured in days of care or number of sessions) that often fall below standards recommended for optimal effects (NIDA, 1999).

- Individuals may have experienced professional treatment, but such treatment may not have played a role in their later achievement of stable recovery.

In spite of such limitations, the vast majority of persons who suffer from substance dependence (in contrast to less severe AOD-related problems) enter recovery through the vehicle of professionally directed treatment (Cunningham 1999a,b, 2000). But this link is not as direct as one might think. Recent studies have shown that a significant portion of

people with the most severe substance use disorders achieve stable recovery only after multiple treatment episodes spread over a number of years (Anglin, Hser, & Grella, 1997; Hser, Grella, Chou, & Anglin, 1998; Dennis, Scott, & Hristova, 2002), suggesting a possible cumulative effect of such interventions.

*Peer-assisted recovery* involves the use of structured recovery mutual aid groups to initiate and/or maintain recovery from AOD problems. Addiction recovery mutual aid structures of many varieties exist in the United States (see discussion below). Alcoholics Anonymous is the most widely used community resource for the resolution of alcohol-related problems (Room, 1989; Weisner, Greenfield, & Room, 1995), with 3.1% of U.S. citizens reporting having attended A.A. meetings sometime in their life for an alcohol problem and 1.5% reporting attendance at A.A. meetings for an alcohol problem in the past year (Room & Greenfield, 1993). Mutual aid involvement, as measured by studies of A.A., can play a significant role in the movement from addiction to recovery (Timko, Moos, Finney, & Moos, 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Emrick, Tonigan, Montgomery, & Little, 1993; Tucker, Vuchinich, & Gladsjo, 1994; Morgenstern, Labouvie, McCray, Kahler, & Frey, 1997; Humphreys, Wing, McCarty, Chappel, & Galant, 2004). This positive effect extends to:

- adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000; Kelly, Myers, & Brown, 2002),
- women and cultural minorities (Denzin, 1987; Caetano, 1993; Humphreys, Mavis, & Stoffelmayr, 1994; Kessler, Mickelson, & Zhoa, 1997; Bischof, Rumpf, Hapke, Meyer, & John, 2000; Winzelberg & Humphreys, 1999),
- persons experiencing substance use and psychiatric disorders (Meissen, Powell, Wituk, Girrens, & Artega, 1999; Ouimette, Humphreys, Moos, Finney, Cronkite, & Federman, 2001),
- persons using medications to support their recovery (Rychtarik, Connors, Demen, & Stasiewicz, 2000), and
- agnostics and atheists (Winzelberg & Humphreys, 1999; Weiss, Griffin, Gallop, Onken, Gastfriend, Daley, Crits-Christoph, Bishop, & Barber, 2000).

For those seeking support from recovery mutual aid groups, there is a dose effect related to meeting participation. The probability of stable remission rises in tandem with the number of meetings attended in the first three years of recovery (Hoffmann, Harrison, & Belille, 1983; Pisani, Fawcett, Clark, & McGuire, 1993; Humphreys, Moos, & Cohen, 1997; Chappel, 1993). Recovery prospects also rise with the intensity of mutual aid involvement, as measured by active application of program concepts, meeting participation (speaking, interacting, leading), participation in pre- and post-meeting rituals, use of mutual aid networks for fellowship and leisure, reading program literature, being sponsored, sponsoring others, and involvement in other service work (Sheeren, 1988; Cross, Morgan, Moonye, Martin, & Rafter, 1990; Johnson & Herringer, 1993; Emrick et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, &

Cohen, 1997). This intensity of participation effect also applies to adolescents (Margolis, Kilpatrick, & Mooney, 2000).

Peer-assisted recovery is also reflected in the growing recovery home movement (most visibly in the Oxford Houses) (Jason, Davis, Ferrari, & Bishop, 2001) and the rapid growth of non-clinical, peer-based recovery support services (White, 2004c).

Natural recovery, treatment-assisted recovery, and peer-assisted styles of recovery are not mutually exclusive. A.A.'s 2004 membership survey reveals that 64% of A.A. members received some type of treatment or counseling prior to joining A.A. and that 65% received professional treatment or counseling after they entered A.A. (Alcoholics Anonymous, 2005). In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to" alcohol and other drugs, 25% reported initiating and sustaining recovery without treatment or mutual aid (Faces & Voices of Recovery, 2001).

### Recovery Initiation Frameworks (Religious, Spiritual, Secular)

There are considerable differences in recovery styles based on the presence or absence of religion or spirituality as an important dimension of the recovery process. There are *religious frameworks of recovery* (sometimes referred to as *faith-based*) in which severe alcohol and other drug problems are resolved within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship, and support of a community of shared faith. Within various religious traditions, the abandonment of addiction is viewed as a byproduct of the experience of religious conversion/affiliation and the reconstruction of a faith-based personal identity and lifestyle. In this framework, recovery is a divine gift of grace rather than something that one does. Religion is viewed, not as an enriching dimension of recovery, but as the catalytic agent that initiates and sustains recovery (White & Whiters, 2005). Religious pathways of recovery are marked by:

- a religious rationale for the roots of addiction (e.g., the Islamic interpretation of alcoholism as a fruit of the tree of *Jahiliyyah* (ignorance/idolatry) (Badri, 1976);
- a mytho-magical personification/demonization of drugs and the addiction process, e.g., the Islamic interpretation of drink and drunkenness as an "infamy of Satan's handiwork" (Badri, 1976, pp. 3-5);
- a religious rationale for restraint and temperance (e.g., the body as the temple of God) (Bible, 1 Cr 3:16-17; Miller, 1995);
- rituals of confession, restitution, and forgiveness as tools of psychological reconstruction;
- the use of prayer, reading, and service to others (e.g., witnessing) as daily rituals of recovery; and
- enmeshment in a community of faith that meets needs once met within the culture of addiction.

Religious and spiritual frameworks of recovery can closely co-exist. For example, there are societies that help A.A. members who share a particular religious orientation pursue work on A.A.'s Step Eleven: "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." Two of the oldest Eleventh Step groups are the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS). Eleventh Step groups usually serve as adjuncts rather than alternatives to A.A. participation (White, 1998).

Spiritual frameworks of recovery overlap with religious pathways of recovery in the sense that both flow out of the human condition of wounded imperfection (what William James, 1902, referred to as "torn-to-pieces-hood"), involve experiences of connection with resources within and beyond the self, and involve a core set of values (e.g., humility, gratitude, and forgiveness) (Kurtz & Ketcham, 1992). Spiritual frameworks of recovery such as Alcoholics Anonymous focus on defects of character (self-centeredness, selfishness, dishonesty, resentment, anger, preoccupation with power and control) as the root of addiction, and provide a means of reaching both into oneself (e.g., self-inventory, developing the traits of honesty, humility, and tolerance) and outside oneself (reliance on a Higher Power, prayer, confession, acts of restitution, acts of service, participation in a community of shared experience) (Miller & Kurtz, 1994; Green, Fullilove, & Fullilove, 1998). Spirituality as a framework of recovery involves the embrace of paradox (e.g., "sober alcoholic"), gaining a degree of control by admitting one's powerlessness, and becoming whole by accepting one's imperfection (Kurtz, 1999). Spirituality as a medium of recovery is rooted in the understanding that: 1) human beings are born with a vacuum inside themselves that craves to be filled with meaning, 2) we can artificially and temporarily fulfill this need through the medium of drug intoxication, and 3) more authentic and lasting frameworks of meaning can displace the craving for intoxication. Religious and spiritual frameworks can overlap (e.g., religion as a vehicle of spirituality) or exist as distinct experiences (spirituality without religion, religion without spirituality). One of A.A.'s innovations was its emancipation of spirituality from its explicitly religious roots.

*Secular recovery* is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or rituals (prayer). Secular recovery rests on the belief in the ability of each individual to rationally direct his or her own self-change processes. Secular recovery groups view the roots of addiction more in terms of irrational beliefs about oneself and the world and ineffective coping strategies than in terms of biology, morality, character, or sin. Secular frameworks of recovery such as Secular Organization for Sobriety and LifeRing Secular Recovery reinforce the "Big Decision" or "Sobriety Priority" ("not using no matter what") through a variety of cognitive and behavioral self-change techniques. Where spiritual and religious frameworks of recovery involve a transcendence of self, secular frameworks of recovery involve an assertion of self (White & Nicolaus, 2005). Where spiritual frameworks of recovery emphasize wisdom (emphasis on experience, search for meaning, freedom rooted in the acceptance of limitation, self-transcendence by connection to a greater whole, strength flowing from limitation), secular frameworks of recovery emphasize knowledge (emphasis on scientific evidence, an assertion of control, self-mastery through knowledge of self and knowledge of one's problem, and strength flowing from personal competence).

All three recovery initiation frameworks share what Morgan (1995a) has described as a 1) re-visioning of self, 2) a re-visioning of one's life-context, and 3) a restructuring of life-stance and lifestyle. All three frameworks share a three-part story-style in which people in recovery report "in a general way what we used to be like, what happened, and what we are like now" (Alcoholics Anonymous, 1939, p. 70). And yet listening to these tales of "rescue and renewal" (Morgan, 1995b), one finds critical differences in the instrument of recovery (the grace/gift of having been changed versus personal ownership of that change), different metaphors and rituals used to initiate and sustain recovery, and different views of the role of a community of shared experience in the recovery process.

## Recovery Initiation Styles

There are three styles of recovery initiation: *quantum change*, conscious *incremental change,* and a less conscious process that sociologists refer to as *drift*.

Quantum change, also referred to as *transformational change*, is distinguished by its vividness (emotional intensity), suddenness (lack of intentionality), positiveness, and permanence of effect (Miller and C'de Baca, 2001). Quantum change can occur as a breakthrough of self-perception or insight (an epiphany) or as a mystical or religious experience. Both experiences produce fundamental alterations in one's perception of self and the world. The liberation from alcohol and other drug problems and related changes flow from these core alterations of identity and values. Quantum change is sometimes experienced as a Damascus-type[3] conversion (religious, spiritual, or secular in nature) that precisely and forever demarks addiction and recovery. Such recovery conversion experiences are rooted in calamity — often referred to as "hitting bottom." Recovery-catalyzing breakthroughs have been described in the research literature as an "existential crisis" (Coleman, 1978), a "naked lunch experience" (Jorquez, 1993), a "rock bottom experience" (Maddux and Desmond, 1980), a "brief developmental window of opportunity" (White, 1996), a "crossroads" (Klingemann, 1991, 1992), an "epistemological shift" (Shaffer and Jones, 1989), and a "radical reorientation" (Frykholm, 1985). Quantum change as a pathway of addiction recovery has a long history and is often the ignition point of historically important abstinence-based healing and religious/cultural revitalization movements (White, 2004b). Quantum change occurs in religious, spiritual, and secular forms. Illustrative of this experience is the report of Samuel Hadley, whose religious conversion at the Water Street Mission in New York City marked the beginning of a lifetime of service to God and other alcoholics.

> *Although up to that moment my soul had been filled with indescribable gloom, I felt the glorious brightness of the noonday sun shine into my heart. I felt I was a free man….From that moment till now I have never wanted a drink of whiskey, and I have never seen money enough to make me take one. I promised God that night that if he would take away the appetite for strong drink, I would work for him all my life. He has done his part, and I have been trying to do mine* (Quoted in James, 1902, p. 203).

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[3] The reference to Damascus refers to the Biblical account of the transformation of Saul of Tarsus, the orthodox Jew and persecutor of Christians, into St. Paul, the Christian missionary, on the road from Jerusalem to Damascus.

While there is a tendency to grant a special quality to these recovery conversion experiences, Bill Wilson cautioned against such glorification.

> *There is a very natural tendency to set apart those experiences or awakenings which happen to be sudden, spectacular or vision-producing….But as I now look back on this tremendous event* [his own transformative change experience]*….it now seems clear that the only special feature was its electric suddenness and the overwhelming and immediate conviction that it carried to me. In all other respects, however, I am sure that my own experience was not different than that received by every AA member who has strenuously practiced our recovery program* (Wilson, 1962).

In contrast to the lightning strike of quantum change, incremental recovery involves a time-encompassing and stage-dependent process of metamorphosis. Researchers have described many stage models of addiction recovery, including:

- Frykholm's (1985) 3-stage model (ambivalence, lengthening periods of abstinence, and emancipation);

- Biernacki's (1986) four-stage model (a resolution to quit either through drift, rational decision, or "rock bottom" experience; a detachment from the physical and social worlds of addiction; managing cravings and impulses and staying clean (abstinent); and becoming ordinary);

- Waldorf's (1983, 1990) six-stage model (going through changes; forming a resolve; cessation experiments; becoming an ex-addict; learning to be "ordinary"; filling the physical, psychological, social, lifestyle void with family work, religion, politics, and mutual aid);

- Brown's (1985) four-stage model (drinking, transition, early recovery, and ongoing recovery);

- Shaffer and Jones' three-stage model (experiencing turning points, active quitting, and relapse prevention);

- Klingemann's (1991) three-stage model (motivation, action, maintenance); and

- Prochaska and colleagues' (1992) six-stage model (precontemplation, contemplation, planning, action, maintenance, and termination).

Stage models suggest that the process of recovery begins before AOD use is moderated or terminated and that, while linear movement through particular stages is possible, the more common experience is a recycling through these stages before permanent recovery is achieved. The repeated sequence that predates recovery stability might be constructed as follows: escalating AOD-related pain (I need to recover), the desire to change (I want to recover), belief in possibility of change (I can recover), commitment (I am going to recover), experiments in abstinence (I am recovering), and movement from sobriety experiments to sobriety identity (I am an ex-addict; I am a recovered/recovering alcoholic/

addict; I no longer use or misuse alcohol or other drugs). Stages of change models are very popular among addiction professionals, but have come under attack for the lack of empirical evidence supporting them (Sutton, 2001; West, 2005).

Quantum change and incremental change have been described as two discrete phenomena, but we have listened to recovery stories in our travels that have dimensions of both. For example, we have seen individuals who repeatedly cycled through preparatory stages of recovery (what we have here referred to as recovery priming) but whose point of recovery stabilization was marked by a profound, life-altering quantum change experience.

The third style of recovery initiation is one of *drift* — the gradual cessation/reduction of AOD use and related problems as a matter of circumstance rather than choice. Here the addict simply "goes with the flow," only to find in retrospect that events and circumstances lead away from drugs and the culture in which his or her drug use was nested (see Waldorf, 1983; Biernacki, 1986, 1990; Granfield & Cloud, 1999). Developmental maturation and environmental change can elicit changes in alcohol and other drug use in some individuals in ways that do not follow the conscious, self-engineered styles of change depicted in stages of change models. For example, some studies of female heroin addicts depict recovery, not as a central goal, a but as an inadvertent outcome of severing contact with former drug-using environments and relationships (Gerstein, Judd, & Rovner, 1979). Some individuals drift out of addiction through processes similar to the processes by which they drifted into addiction, including finding an intense alternative pursuit that gives new meaning to one's life (Cloud & Granfield, 2001).

### Recovery Identity

Recovery styles also reflect different *recovery identity* patterns — variations in the extent to which AOD problems and the recovery process influence one's identity, and the degree to which one identifies with other people who share this recovery process. There are those with recovery-neutral identities (persons who have resolved severe AOD problems but who do not self-identify as "alcoholics," "addicts," or "persons in recovery"), those with recovery-positive identities (those for whom the status of recovery from addiction has become an important part of their personal identities), and those with recovery-negative identities (those whose addiction/recovery status is self-acknowledged but not shared with others due to a sense of personal shame derived from this status).

These identities, rather than being mutually exclusive, can constitute different points in a prolonged recovery career. For example, we have witnessed such evolution in the modern history of recovering people working as addiction counselors. Early addiction counselors boldly proclaimed their recovery status as their primary credential, but began withholding that recovery status in the 1980s and 1990s behind their accumulating credentials and the restigmatization of AOD problems. In the face of a new recovery advocacy movement calling upon recovering people to put a face and voice on recovery, many of those same addiction counselors are again going public with their recovery status. In our experience, evolution in identity is the norm in addiction recovery.

## Recovery Relationships

There are acultural *styles of recovery* in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery and without identification with a larger *recovery community* or *culture of recovery* (a social network of recovering people with their own recovery-based history, language, rituals, symbols, literature, and values). This is not to say that this style of recovery is void of social support, but that support usually comes from one's inner family and social circle rather than from a larger community of recovering people. Gerry Spense, the noted trial lawyer, describes this style of recovery:

> *We (Gerry and his new wife) sort of became each other's A.A. We quit together, and we hung on to each other. Although I have never attended an Alcoholics Anonymous session, we must have had the kind of experience that people have there.* (Quoted in *Wholey, 1984, p. 106.)*

In contrast, there are *bicultural styles of recovery,* in which individuals sustain their recovery through simultaneous involvement in a culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). There are also *enmeshed styles of recovery,* in which one initiates and maintains recovery in almost complete sequestration within a culture of recovery (White, 1996).

These styles are not mutually exclusive and can change over the course of recovery, with some individuals exhibiting very enmeshed styles of early recovery, only to migrate toward a bicultural or acultural style of recovery later in their lives. Some individuals use recovery mutual aid groups for recovery initiation and maintenance, where others seem to initiate recovery through such resources, but then sustain that recovery through their own personal, family, and social resources. Some continue Twelve Step or other recovery maintenance practices without meeting participation, while others find other sources of long-term recovery support (Tonigan, Miller, Chavez, Porter, Worth, Westphal, Carroll, Repa, Martin, & Tracy, 2002). A relatively recent phenomenon is the advent of *virtual (Internet) recovery* — the achievement or maintenance of recovery through Internet support groups, with little or no participation in face-to-face support meetings. Web-based recovery support services include email and instant messaging systems, newsgroups, bulletin boards, chat rooms, self-assessment instruments, and recovery coaching (Walters, Hester, Chiauzzi, & Miller, 2005). The Internet seems to elicit a much higher degree of participation among women and individuals in high-status occupations than do either professional treatment or face-to-face recovery mutual aid groups (Hall & Tidwell, 2003).

*Communities of recovery* is a phrase coined by Ernest Kurtz to convey the existence of multiple recovery communities. Addiction treatment professionals should refer people to these communities with the goal of achieving reciprocity of fit between the individual and the group. Style differences based on the evolution in how one relates (or does not relate) to these communities of recovery are part of what could be described as one's *recovery career*. The concept of *career* has been applied to the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Timko, Moos, Finney, Moos, & Kaplowitz, 1999;

Dennis, Scott, Funk, & Foss, 2005). *Recovery career* is an extension of this application and refers to the evolving stages of recovery stability and one's identity and recovery support relationships over time.

### Varieties of Twelve-Step Experience

Peer-based support groups constitute a major resource for the resolution of alcohol and other drug problems (Room & Greenfield, 1993; Kessler, Mickelson, & Zhoa, 1997; Kissin, McLeod, & McKay, 2003). Such groups are attractive, are geographically accessible and affordable, require no formal admission procedures, and place no limits on length of participation (Humphreys, et al., 2004). Twelve-Step groups began with the founding of Alcoholics Anonymous in 1935. Although there were dozens of recovery mutual aid societies that pre-dated A.A. (White, 2001), A.A. continues to be the standard by which other mutual aid groups are measured due to its size (2.1 million members in 100,766 groups), geographical growth (150 countries), and longevity (Kurtz & White, 2003). Varieties of A.A. experience were evident from its inception (e.g., differences between A.A. in Akron and New York City) and have grown throughout A.A.'s history.

Varieties of A.A. experience are reflected in the diversity of A.A. meeting formats (e.g., open vs. closed meetings, speaker meetings vs. discussion meetings), in the trend to organize A.A. around special populations and special needs, and in the wide variance of styles of "working" the A.A. program. Local A.A. meeting lists reflect such specialization, e.g., meetings organized by age (young people's meetings, old-timers meetings), gender (women-only and men-only meetings), sexual orientation (lesbian, gay, bisexual, transgender), language (Spanish, Polish, no profanity), profession (physicians, lawyers, airline pilots), social status (off-the-books meetings for celebrities and those in high-status positions), relationship status (single, couples), co-occurring problems (psychiatric illness, HIV/AIDS), and smoking status (non-smoking), to name just a few. There are differences in A.A. that transcend filtering the A.A. program through particular types of categorical/cultural experience. Significant differences can be found in A.A. meetings related to such factors as degree of religious orientation (from efforts to Christianize A.A. to A.A. groups for atheists and agnostics), meeting rituals, pre- and post meeting activities; and basic interpretations of the nature of the A.A. program (Kurtz & White, 2003). Such varieties multiply exponentially when one examines the range of adaptations of A.A.'s Twelve Steps to other drug problems (e.g., Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, Pills Anonymous, Methadone Anonymous) and to co-occurring problems (e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery).

The explosive growth of A.A. in the 1970s and 1980s and the growing influence of the addiction treatment industry and the criminal justice system upon A.A. (via mandated A.A. attendance) led to concerns among A.A. old-timers that the core of A.A.'s program was being corrupted. This concern led to efforts to define and recapture the historical A.A. A.A. historian Ernest Kurtz (1999, pp. 131-138) proposed five criteria to distinguish "real A.A." from meetings that had taken on the flavor of treatment groups: 1) A.A. vocabulary (defects of character, self-inventory, Higher Power) rather than treatment vocabulary; 2) humor and the appreciation of paradox; 3) a story style that "describes in a general way what we used to be like, what happened, and what we are like now"; 4) respect for and

adherence to A.A. traditions; and 5) a conviction by those attending meetings that they NEED rather than WANT to be there.

The growing varieties of A.A. experience triggered efforts in the scientific community to define the "active ingredients" of A.A. These scientists, confronted with the large menu of concepts and activities that make up the A.A. experience, attempted to define which aspects of the A.A. experience were the most potent in altering the course of alcoholism and strengthening the recovery experience. To-date, these studies have focused on such mechanisms as motivational enhancement, development of Twelve-Step cognitions (e.g., commitment to abstinence and continued A.A. participation), recovery coaching (advice), mastery of behavioral prescriptions for coping, exposure to recovery role models, enhanced self-efficacy, changes in friendship networks, and the therapeutic benefits of helping others (Morgenstern, et al., 1997; Humphreys, Mankowski, Moos, & Finney, 1999; Pagano, Friend, Tonigan, & Stout, 2004). Scientists have also plotted a continuum of response to Twelve-Step involvement across three populations: optimal responders, nonresponders, and partial responders (Morgenstern, Kahler, Frey, & Labouvie, 1996).

Other areas of diverse experience within Twelve-Step groups include patterns of co-attendance of Twelve Step and other groups, e.g., attending A.A. and Al-Anon, A.A. and N.A., A.A. and Women for Sobriety; patterns of primary affiliation (e.g., shifting primary allegiance from N.A. to A.A.); patterns of intensity of participation (frequency of meeting attendance and other Twelve-Step practices); and duration of participation over time (e.g., decreasing involvement or disengagement from regular involvement in meetings and rituals).

### Still Other Varieties

The existence of those who did not respond or only partially responded to spiritually oriented Twelve-Step programs set the stage for the emergence of explicitly religious and secular frameworks of peer-based recovery support (Humphreys, 2004). Religious recovery support groups include (with their founding dates where available) Alcoholics Victorious (1948), Teen Challenge (1961), Alcoholics for Christ (1976), Overcomers Outreach (1977), Liontamers Anonymous (1980), Mountain Movers, High Ground, Free N' One, Victorious Lady, Celebrate Recovery, Millati Islami, and innumerable local recovery-support ministries. As noted earlier, these groups share a religious interpretation of the roots of addiction (e.g., as a sin of the flesh, idolatry, or demonic possession), recovery founded on total surrender to a religious deity, a religiously based reconstruction of personal identity and values, and immersion in a faith-based community (White & Whiters, 2005).

Secular recovery support groups (with their founding dates) include Women for Sobriety (WFS) (1975), Secular Sobriety Groups (later renamed Secular Organization for Sobriety — Save Our Selves (SOS) (1985), Rational Recovery (RR) (1986), Men for Sobriety (MFS) (1988), Moderation Management (MM) (1994), SMART Recovery® (1994), and LifeRing Secular Recovery (LSR) (1999). Secular groups are distinguished by their meeting locations (homes and religiously neutral sites); lack of reference to religious deities; discouragement of self-labeling ("alcoholic" and "addict"); emphasis on personal em-

powerment and self-reliance; openness to crosstalk (direct feedback and advice between members); lack of formal sponsorship; encouragement to complete a recovery process and move on to a full, meaningful life (rather than sustain meeting participation for life); and use of volunteer professional advisors (persons not in personal recovery) to facilitate and speak at meetings (White & Nicolaus, 2005).

Individuals who participate in Twelve-Step alternatives may do so exclusively, concurrently with A.A. meetings, or sequentially (using one framework to initiate recovery and another framework to maintain and enrich that recovery over time (Kaskutas, 1992; Connors, Dermen & Duerr, 1992; White & Nicolaus, 2005).

### Recovery Durability

Interest has grown over the past decade in the prospects and processes involved in long-term recovery stabilization (Morgan, 1995; Chappel, 1993), as it has become clear that short periods of sobriety or decelerated AOD use are not predictive of sustained recovery. Some researchers have claimed that stable remission can be predicted by as little as six months of sobriety (Armor, Polich, & Stambul, 1978). Vaillant (1983), in a prospective study of alcoholic men, found that the stability and durability of addiction recovery increases with length of sobriety, with no relapses in his study among those who had achieved six or more years of continuous sobriety. A growing number of studies are suggesting that the point at which most recoveries from alcohol dependence become fully stabilized is between four and five years of continuous remission (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, O'Donnel, & De Soto, 1989; Dawson, 1996; Jin, Rourke, Patterson, Taylor & Grant, 1998). Once attained, recovery from alcohol dependence is more stable for those with late-onset alcohol problems compared to those with early-onset alcohol problems (Schutte, Brennan & Moos, 1994).

Studies of heroin addicts further confirm the fragility of short periods of abstinence. Follow-up studies have demonstrated that only 42% percent of those abstaining from opiates in the community at two-year follow-up were still abstinent at five-year follow-up (Duvall, Lock, & Brill, 1963). One third of those who achieve three years of abstinence eventually relapse (Maddux & Desmond, 1981), and one quarter of heroin addicts with five or more years of abstinence later return to heroin use (Hser, Hoffman, Grella, & Anglin, 2001).

While recovery stability seems to vary somewhat across drugs used, the principle that recovery becomes more stable over time seems to apply to all patterns of addiction. In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to alcohol or other drugs," half reported being in stable recovery more than five years, and 34% reported having achieved stable recovery lasting ten or more years (Faces & Voices of Recovery, 2001). The average length of continuous sobriety reported in the latest membership survey of Alcoholics Anonymous was 8 years, with 36% of A.A. members reporting continuous sobriety of more than 10 years (*A.A. Grapevine*, July, 2005).

Persons who achieve full, uninterrupted recovery for five years, like persons who have achieved similar patterns of symptom remission from other primary health disorders, can be described as *recovered*. In general, this means that the risk of future lifetime relapse

has approached the level of addiction risk for persons without a history of prior addiction. Those who achieve full symptom remission for less than five years or who have achieved partial recovery (marked reduction of AOD use and related consequences) can best be described as *in recovery* or *recovering*. Use of the term *recovering* in later years (after five years) of recovery reminds the individual that recovery is an enduring process requiring sustained vigilance and recovery maintenance. However, such use, by inadvertently conveying the lack of a permanent solution for severe AOD problems, may contribute to the stigma and pessimism attached to these problems.

### Recovery Termination

One of the recent controversies related to recovery from addiction involves the question of whether addiction recovery is ever fully completed. The stage models of recovery summarized earlier collectively portray four broad stages of recovery: 1) *recovery priming* (experiences that open a doorway of entry into recovery), 2) *recovery initiation* (discovering a workable strategy of problem stabilization), 3) *recovery maintenance* (achieving recovery stability and sustaining and refining broader strategies of problem resolution with a continued focus on the recovery process), and 4) *recovery termination* (achievement of global health with diminished preoccupation with recovery). This last stage, referred to as *Stage II Recovery* ("rebuilding the life that was saved in Stage I") (Larsen, 1985, p. 15), transcends the early concern with the addictive behavior and focuses on a reconstruction of personal character, identity, beliefs, and interpersonal relationships. This stage is also referred to as *completed recovery* or the *real thirteenth step*[4] — an "advanced state" of recovery marked by global health and a heightened capacity for intimacy, serenity, self-acceptance, and public service (Picucci, 2002; Tessina, 1991).

### Implications for the Professional Treatment of AOD Problems

This review contains critical understandings that could help shape recovery-oriented systems of care. Some of the most important of these include the following.

**Paradigmatic Shift:** There will be increasing calls to shift addiction treatment and addiction counseling from a problem-focused or intervention-focused paradigm to a recovery paradigm. This will shift the emphasis of treatment from one of brief biopsychoscial stabilization to one of sustained recovery management (pre-recovery engagement; recovery initiation; sustained monitoring; stage-appropriate recovery education and coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention) (White, Boyle & Loveland, 2003).

**Recovery Definition and Scope:** The shift to a recovery paradigm will require considerable discussion between the professional addictions field and diverse communities of recovery about the very definition of recovery. These discussions will be contentious, but we would make the following predictions:

1. Abstinence will shift from its status as a *goal* and definitional requirement of recov-

[4] The thirteenth step is a euphemism for romantic involvement between AA members and, more specifically, the sexual overture by an older AA member to a newly sobered AA member.

ery to the status of *one method* of achieving recovery (and the preferred method for those with the most severe AOD problems). The goal will shift to the resolution of AOD problems by any means possible — a goal that will legitimize moderated outcomes for those with less severe AOD problems.

2. The focal point of recovery (changes in one's primary drug relationship) will broaden to include a healthy relationship or non-relationship with all psychoactive drugs and the achievement of global health. Addiction treatment programs will increasingly be held accountable for multiple recovery outcomes, e.g., changes in primary and secondary drug use as well as changes in physical, emotional, family/relational, and occupational/academic health and functioning. There will be a shift in focus from what recovery eliminates (AOD use and related problems) to what recovery adds to individuals, families, and communities (global health, occupational and academic productivity, active citizenship) (http://www.samhsa.gov/Matrix/SAP_treatment.aspx).

3. Re-elevating the concept of *family recovery* will exert pressure for new technologies of family assessment, intervention, and sustained monitoring as well as impetus for a family-oriented recovery research agenda.

4. The concept of *partial recovery* will receive greater elucidation and legitimacy within the addictions treatment field, and cases of *enriched recovery* (dramatically elevated health, functioning, and community service) will be documented and culturally elevated to help ameliorate the social stigma that continues to be attached to AOD problems.

**Recovery Capital:** The pathology and intervention paradigms that have guided addiction treatment have shaped assessment and placement protocol so that they focus almost exclusively on problem severity and complexity. The resiliency/recovery paradigm calls for measuring recovery capital; distinguishing the role of recovery capital in *natural*, *treatment-assisted*, and *peer-assisted* recoveries; and giving prominence to an individual's/family's recovery capital within the process of clinical decision-making. The most important implication of the concept of recovery capital is the premise that not all individuals experiencing AOD problems need professional treatment. Individuals with lower problem severity and high recovery capital can be encouraged to explore natural and peer-based resources as less restrictive, less expensive, and less stigma-laden alternatives to addiction treatment. Monitoring responses to such resources can be used to determine if and when professional services are necessary.

**Medication-Assisted Recovery:** Tension is growing between an anti-medication bias within the field of addiction treatment (and within American communities of recovery and the larger American culture), the growing availability of a wide variety of pharmacological adjuncts in the treatment of addiction, and the growth in scientific evidence supporting their effectiveness. We anticipate a day when the legitimacy of such pharmacological adjuncts will be widely recognized in professional and recovery communities and integrated within the large spectrum of treatment and recovery support services. If such legitimacy is not achieved, we would anticipate a schism within the field in which more scientifically and medically based treatments split off into a separate field within primary medicine. We

would consider this further splitting of body from mind and soul a tragic event in the history of the field.

**Recovery Frameworks:** Religious, spiritual, and secular frameworks of recovery must be more completely charted and evaluated, with a particular focus on their applicability to particular cultural and clinical populations. For example, researchers have extensively studied (some would say over-studied) AOD problems in Native American and African American communities, but no comparable quantity of literature exists on the varieties of recovery experience within these communities. How many African Americans initiate and sustain recovery through the historical Black church? How many African Americans initiate recovery through A.A. or N.A. and then migrate into the Black church to sustain their recoveries? How many Native Americans use indigenous cultural or religious revitalization movements as a framework for long-term sobriety? In the same vein, how do members of secular frameworks of recovery differ from those in religious or Twelve-Step frameworks of recovery? What mechanisms of change are shared across religious, spiritual, and secular frameworks of recovery; and what mechanisms of change distinguish such frameworks from each other? Definitive, scientifically researched answers to such questions do not yet exist.

**Recovery Styles:** Variations in how recovery is initiated and how recovery shapes personal identity and interpersonal relationships illustrate the diversity of experiences that constitute recovery from AOD problems. Further documentation of such styles and their relative prevalence across cultural and clinical subpopulations is needed to guide the delivery of treatment and recovery support services. The elucidation of recovery styles is part of a larger recovery research agenda that is currently gaining prominence.

**Varieties of Recovery Mutual Support Societies:** The numerical expansion and growing diversity of peer-based recovery support groups suggests the need for all addictions professionals to become students of such groups, develop relationships with these groups, provide clients information about such groups, and develop a style of active linkage to these groups. The diversity of recovery support groups has prompted calls for matching individual clients to particular groups by such factors as age, gender, socioeconomic status, drug of choice, smoking status, and attitudes toward religion and spirituality (Forman, 2002; White & Nicolaus, 2005). Celebration of the growing diversity of recovery pathways and a philosophy of choice permeate the philosophies of the best treatment programs. Recent reviews of treatment effectiveness have linked this philosophy of choice to enhanced motivation and treatment outcomes (Hester & Miller, 2003). All recovery support structures, like all treatments, will have optimal responders, partial responders, and non-responders. This calls for continued monitoring and support to get the best possible fit between each individual and a particular method of treatment or recovery support. Combinations of natural resources, peer recovery networks, and professional treatment may generate amplified recovery outcomes for those individuals and families with the greatest problem severity and complexity.

## Summary and Conclusions

The extension of the pathology and intervention paradigms toward a recovery paradigm

will generate significant new understandings about the varieties of recovery experience. However, our understanding of those varieties is in its infancy. It is time the recognition of multiple pathways and styles of recovery moved beyond the level of superficial rhetoric. It is time the field aggressively pursued a recovery research agenda. It is time that the recognition of multiple pathways and styles of recovery fully permeated the philosophies and clinical protocols of all organizations providing addiction treatment and recovery support services.

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# Recovery Management

## What if we really believed that addiction was a chronic disorder?

William L. White, MA

*A quiet revolution is unfolding within the worlds of addiction treatment and recovery support. This revolution is founded on new understandings of the nature of substance use disorders and their management. It calls for shifting the treatment of severe and persistent alcohol and other drug (AOD) problems from an emergency room model of acute care (AC) to a model of sustained recovery management (RM). The RM model wraps traditional interventions in a continuum of recovery support services spanning the pre-recovery (recovery priming), recovery initiation and stabilization, and recovery maintenance stages of problem resolution. Particularly distinctive is the model's emphasis on post-treatment monitoring and support; long-term, stage-appropriate recovery education; peer-based recovery coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention.*

### Promotional Forces

There are several forces pushing the addiction field toward a redesign of its treatment processes. Frontline addiction professionals are articulating (and a growing number of scientific studies are confirming) the limitations of addiction treatment as currently practiced. Grassroots recovery advocacy organizations are calling upon the treatment industry to reconnect professional treatment to the larger and more sustained process of addiction recovery. Pioneer states (e.g., Connecticut) are building research, clinical, and recovery advocacy coalitions to infuse the recovery management model into new "recovery-oriented systems of care." And finally, technological advances in the management of primary chronic health care problems (e.g., diabetes, heart disease, asthma, arthritis, cancer, chronic lung disease, glaucoma, irritable bowel syndrome) are suggesting alternative approaches through which severe and complex behavioral health disorders might be managed more effectively.

### Premises

The shift from acute care to sustained recovery management models rests upon six propositions.

1. *Alcohol and other drug problems present in transient and chronic forms*. The transient forms vary in intensity, from the clinical (*substance abuse* and *substance dependence*) to the subclinical (problems not meeting DSM-IV criteria for abuse or dependence). Transient forms share a short duration (a single episode or period of problematic use) and a propensity for natural resolution or resolution through brief professional intervention. Transient AOD problems are common in community populations, but are more rarely represented among populations entering addiction treatment. Compared to community populations, clients entering addiction treatment

are distinguished by:

- greater personal vulnerability (e.g., family history of substance use disorders, early age of onset of AOD use, developmental trauma),
- greater severity and intensity of use and related consequences,
- high concurrence of medical/psychiatric illnesses,
- greater personal and environmental obstacles to recovery, and
- less "recovery capital" (the internal and external resources required to initiate and sustain recovery).

2. *The evidence is overwhelming that the course of severe substance use disorders and their successful resolution (addiction, treatment, and recovery careers) can span years, if not decades.* Alcohol and other drug dependencies resemble chronic disorders (e.g., type 2 diabetes mellitus, hypertension, and asthma) in their etiological complexity (interaction of genetic, biological, psychological, and physical/social environmental factors), onset (gradual), course (prolonged waxing and waning of symptoms), treatment (management rather than cure), and clinical outcomes. To characterize addiction as a chronic disorder is not to suggest that recovery is not a possibility. There are millions of people in stable, long-term recovery from addiction. The notion of addiction as a chronic disorder does, however, underscore the often-long course of such disorders and the sustained "treatment careers" that can precede stable recovery. Recent studies have confirmed that the majority of people with severe and persistent substance use disorders (e.g., substance dependence) who achieve a year of stable recovery do so following 3-4 treatment episodes over a span of eight years.

3. *Severe and persistent AOD problems have been collectively depicted as a "chronic, progressive disease" for more than 200 years, but their historical treatment more closely resembles interventions into acute health conditions (e.g., traumatic injuries, bacterial infections)*. If we (the practitioners of addiction treatment) really believed addiction was a chronic disorder, we would not:

   - view prior treatment as a predictor of poor prognosis (and grounds for denial of treatment admission);
   - convey the expectation that all clients should achieve complete and enduring sobriety following a single, brief episode of treatment;
   - punitively discharge clients for becoming symptomatic;
   - relegate post-treatment continuing care services to an afterthought;
   - terminate the service relationship following brief intervention; or

- treat serious and persistent AOD problems in serial episodes of self-contained, unlinked interventions.

4. *Acute models of treatment are not the best frameworks for treating severe and persistent AOD problems*. The limitations of the acute model of addiction treatment as currently practiced include:

   - Failure to Attract: Less than 10% of U.S. citizens who meet DSM-IV criteria for substance abuse or dependence currently seek treatment, and most of those admitted to treatment arrive under coercive influences.

   - Failure to Engage/Retain: More than half of the people admitted to addiction treatment in the U.S. do not successfully complete treatment, and 18% of people admitted to addiction treatment are administratively discharged from treatment.

   - Inadequate Service Dose: A significant percentage of individuals completing treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.

   - Lack of Continuing Care: Post-discharge continuing care can enhance recovery outcomes, but only one in five clients actually receives such care.

   - Recovery Outcomes: The majority of people completing addiction treatment in the U.S. resume AOD use in the year following treatment, most within 90 days of discharge from treatment.

   - Revolving Door: Of those admitted to publicly funded addiction treatment, 60% already have one or more prior treatment admissions, and 24% have three or more prior admissions. Between 25% and 35% of clients who complete addiction treatment will be re-admitted to treatment within one year, and 50% will be re-admitted within 2-5 years.

   A large number of people are undergoing repeated episodes of brief interventions whose designs have little ability to fundamentally alter the trajectory of substance dependence and its related consequences. This failure does not result from client foibles or the inadequate execution of clinical protocol by service professionals. It flows instead from a fundamental flaw in the design of the intervention — an acute-care model of treating addiction that is analogous to treating diabetes or asthma through a single, self-contained episode of inpatient stabilization. In the AC model, brief symptom stabilization is misinterpreted as evidence of sustainable recovery.

5. *Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months, and years following treatment. Recent studies have confirmed the fluidity of post-treatment adjustment.* One such study 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. Beyond the groups of clients who categorically succeed or do not succeed stands a larger body of clients who vacillate between periods of recovery and periods of re-addiction. The precarious nature of early recovery is further confirmed by longer-term studies finding that stable recovery from alcoholism (the point at which the future risk of lifetime relapse drops below 15%) is not achieved until 4-5 years of continuous recovery, and that stable recovery from opiate addiction takes even longer. Such findings beg for models of sustained post-treatment monitoring and support.

## Promises and Prospects

Recovery management models hold great promise in treating severe and complex substance use disorders. Chronic disorders are disorders that resist cure via brief intervention but can often be successfully managed (the achievement of full or partial recovery). Such management entails care and sustained support aimed at enhancing the strength, quality, and durability of remission periods and shortening the frequency, duration, and intensity of relapse episodes. This longer-term vision of the treatment and recovery process is based on several critical assumptions:

- A single brief episode of treatment rarely has sufficient effect for those with the most severe substance use disorders to sustain recovery following the intervention.

- Multiple episodes of treatment, if they are integrated within a recovery management plan, can constitute incremental steps in the developmental process of recovery.

- Treatment episodes over time may generate cumulative effects.

- Particular combinations and sequences of professional treatment interventions and peer-based recovery support services may generate synergistic effects (dramatically elevated long-term recovery outcomes).

RM models are focusing initially on the power of post-treatment monitoring and recovery support services. Early studies are confirming the potential utility of such approaches. One study of recovery management checkups (RMC) and early re-intervention over 24 months following treatment found that members of the RMC group had significantly fewer post-treatment days of substance use, were more likely to return to treatment, were more likely to return to treatment sooner, received treatment on a greater number of days following discharge from the index episode, and experienced fewer quarters during follow-up in which they were in need of treatment.

Treating alcohol and other drug dependence solely through repeated episodes of detoxification and brief stabilization is clinically ineffective and constitutes a poor stewardship of personal and community resources. It contributes to the pessimism of clients, service providers, policy makers, and the public regarding the prospects for permanent resolution of alcohol and other drug problems. It is time we acted as if we really believed addiction was a chronic disorder. Today millions of people are reaping the fruits of recovery while others continue to suffer. It is time we widened the doorway of entry into recovery

for those with the most severe and persistent substance use disorders. To achieve that will require changes in our thinking, changes in our clinical technologies, and changes in systems of service reimbursement.

## Model Definition

The recovery management model of addiction treatment shifts the focus of care from professional-centered episodes of acute symptom stabilization toward the client-directed management of long-term recovery. It wraps traditional interventions within a more sustained continuum of:

- pre-recovery support services to enhance recovery readiness,
- in-treatment recovery support services to enhance the strength and stability of recovery initiation, and
- post-treatment recovery support services to enhance the durability and quality of recovery maintenance.

The influence of this emerging model is evident in many quarters. It is evident in the research community's exploration of addiction as a chronic disease (O'Brien & McLellan, 1996; McLellan, Lewis, O'Brien, & Kleber, 2000). It is reflected in the work of the Behavioral Health Recovery Management project in Illinois (White, Boyle, & Loveland, 2003a/b) and other pioneer state efforts to reshape addiction treatment into a "recovery-oriented system of care" (e.g., see http://www.dmhas.state.ct.us/recovery.htm). Interest in recovery management at the federal level is revealed in the move toward a more recovery-oriented research agenda at NIAAA and NIDA, in SAMHSA and CSAT's growing interest in peer-based models of recovery support services (particularly within CSAT's Recovery Community Support Program), and in the White House-initiated Access to Recovery program funded amd administered by CSAT. Private sector interest in recovery-focused treatment system enhancements is reflected in the Robert Wood Johnson Foundation's Paths to Recovery Initiative (http://www.pathstorecovery.org). The shift from acute intervention models to models of sustained recovery support are further reflected in the policy agendas of new grassroots recovery advocacy organizations across the country (see http://www.facesandvoiceofrecovery.org).

Describing the emerging "model" of recovery management is a bit like describing a painting while it is being created, but there are broad principles and early changes in clinical practices that are becoming visible. There may be no single program in the country that reflects all the changes described below, but these changes do collectively represent what is increasingly being characterized as a model of *recovery management*.

## Model Principles

There are several cornerstone beliefs that distinguish the recovery management model from acute models of addiction treatment. These principles and values include:

- emphasis on resilience and recovery processes (as opposed to pathology and disease processes),
- recognition of multiple long-term pathways and styles of recovery,
- empowerment of individuals and families in recovery to direct their own healing,
- development of highly individualized and culturally nuanced services,
- heightened collaboration with diverse communities of recovery, and
- commitment to best practices as identified in the scientific literature and through the collective experience of people in recovery. (http://www.bhrm.org/papers/principles/BHRMprinciples.htm and http://www.dmhas.state.ct.us/corevalues.htm)

## Model Practices

White, Boyle, and Loveland's (2003a/b) review of recovery management (RM) pilot programs reveals several critical differences between the RM models and traditional acute care (AC) models of intervention. These differences span seven broad areas of clinical practice.

Engagement and Motivational Enhancement: RM models place great emphasis on engagement and motivational enhancement. This emphasis is reflected in low thresholds of engagement (inclusive recruitment and admission processes), an investment in outreach and pre-treatment support services, and high retention and low post-admission extrusion (administrative discharge) rates. Within the RM model, motivation is viewed as an important factor in long-term recovery, but is viewed as something that emerges within the service relationship rather than a precondition for service initiation. This emphasis is based on two premises: 1) chronic disorders increase in complexity and severity over time, and 2) recovery outcomes are enhanced by the earliest possible point of recovery initiation and stabilization. AC models of addiction treatment are essentially reactive in their wait for individuals to enter states of crisis that bring them to treatment. RM models reach out to people prior to such crises and sustain contact with them to re-nurture motivation for recovery following such crises.

Assessment and Service Planning: In traditional treatment, the clinical assessment is categorical (focused on substance use and its consequences), is pathology-based (focused on the identification and elucidation of problems), and is an intake activity. Problem severity dictates level of care, and the problems list drives the development of the treatment plan. In recovery management models, assessment is global (focused on the whole life of the recovering person), asset-based (focused on recovery capital — internal and external assets that can help initiate and sustain recovery), and is continual over the span of the service relationship. This altered view of the assessment process is based on three propositions:

1. Chronic disorders beget other acute and chronic problems; therefore, all aspects of

the life of the recovering person must be assessed and incorporated into an integrated recovery process.

2. Service intensity and duration are dictated by the interaction of problem severity and recovery capital; therefore, problem severity alone is an inadequate and disempowering framework for service planning.

3. There are developmental stages of long-term recovery, and service and support needs can shift dramatically in the transition from one stage to another; therefore, stage-dependent service needs must be continually reevaluated.

The traditional professionally directed, short-term treatment plan of the acute care model is replaced in the RM model by long-term and short-term recovery plans prepared by the person seeking recovery. The former focuses primarily on reducing pathology; the latter focuses on building recovery capital and a meaningful life.

Service Duration and Emphasis: Acute care models do an excellent job of biopsychosocial stabilization, but often fail to facilitate the transition between recovery initiation and recovery maintenance. The evidence of such failure can be found in post-treatment relapse and treatment re-admission rates (see previous article in this series). Recovery management models rest on the assumption that the factors required to sustain recovery over a lifetime are different than those factors that spark brief sobriety experiments. The recovery management model emphasizes four post-treatment service activities: sustained post-stabilization monitoring; stage-appropriate recovery education and coaching; assertive linkage to local communities of recovery; and, when needed, early re-intervention. Detoxification and traditional treatment exist within RM models, but the focus of service shifts from crisis intervention to post-treatment recovery support services.

Locus of Services: The institutional focus of the acute care model ("How do we get the addicted person into treatment?") shifts within the RM model to the larger community ("How do we nest the process of recovery within the client's natural environment?"). With this shift, there is a greater emphasis on home- and neighborhood-based services and indirect monitoring technology (e.g., telephone, mail, Internet), as well as an emphasis on organizing indigenous recovery support services within the client's physical and social environment. The RM model also pushes treatment agencies toward greater advocacy responsibilities related to stigma and discrimination, the removal of environmental obstacles to recovery, and the development of needed recovery support resources within local communities.

Role of the Client: In acute care models of intervention, the person entering treatment is viewed as the major obstacle to his or her own recovery, and thus is dependent upon an expert who assumes fiduciary responsibility for diagnosis and treatment. RM models champion the necessity and right of the person who is seeking recovery to self-manage his or her own recovery process. Each client must become an expert on his or her condition and its management. This emphasis is reflected in the client's role in service planning and evaluation, as well as in the RM model's inclusion of recovering people and family members in policy-making positions and as volunteers and paid service providers.

Service Relationship: The service relationship within the RM model shifts from one that is hierarchical, time-limited, and highly commercialized (the AC model) to one that is less hierarchical, more time-sustained, and more natural. In the RM model, the service provider role is more that of a teacher and ally within a long-term health care partnership. RM models are also pioneering new approaches to peer-based recovery support services that utilize new service roles, e.g., peer counselors, recovery coaches, recovery support specialists (White, 2004). The RM model emphasizes the importance of sustained continuity of contact in a primary recovery support relationship. This relationship would be analogous to the long-term alliance between a primary care physician and his or her diabetic patient or the long-term support that exists within addiction recovery mutual aid societies.

Model Evaluation: The evaluation of acute care models of addiction treatment focuses on measuring the short-term effects of a single, brief episode of intervention. Evaluation within the RM model focuses on measuring the long-term effects of multiple service interventions. The goal is to identify particular combinations or sequences of clinical and recovery support services that generate dramatically elevated (cumulative or synergistic) effects upon recovery outcomes within particular populations. The RM model also balances science-based evaluations of service outcomes with consumer and community/tribal evaluations of service processes and recovery outcomes.

Today, elements of the RM model exist within many traditional treatment programs that have evolved toward more client-responsive clinical policies and practices. Elements of the model exist within CSAT's Recovery Community Support Program and RWJ's Paths to Recovery grantee sites. The model is being tested within research studies that are evaluating elements of the RM model. It exists within the growing network of recovery homes and recovery support centers. The recovery management model of intervening with severe substance use disorders marks a dramatic change in the design of addiction treatment in the United States. Time will tell whether this model will struggle as a loosely attached appendage to the existing system of addiction treatment or whether it will transform addiction treatment in the United States into a truly recovery-oriented system of care and long-term support.

### Implementation Challenges

The scientific evidence documenting the need to shift addiction treatment from an acute model of intervention to a model of sustained recovery management is so overwhelming it leaves one wondering why this model is not yet fully implemented. The roots of this failure are historical, conceptual, financial, organizational, and technical.

The first barriers to treating addiction as a chronic disorder are the forces of historical and conceptual momentum. The modern field of addiction treatment is rooted in an acute biopsychological model of intervention. Addiction treatment programs were created in the image of the acute care hospital (via the profound influence of hospital-derived accreditation standards). The central service role in addiction treatment was similarly modeled after the therapy disciplines of psychiatry, psychology, and social work (via addiction counselor certification and licensure standards). For those of us steeped in the modern

world of addiction treatment, it is almost impossible to think of treatment in terms other than number of days or number of sessions, and hard to think about continuing care as anything beyond the availability of a short regimen of "aftercare" sessions. We have viewed addiction treatment in terms of multiple levels of care and theory-based modalities, but have failed to recognize that all of these approaches are nested within an acute care model of assess, admit, treat, and discharge. To escape this closed conceptual world, programs exploring the RM model are re-educating their service workers and are conducting a rigorously honest, recovery-focused inventory of their current service practices.

All of the reimbursement and regulatory systems that govern addiction treatment are based on the acute care model. These structures, originally designed to elevate the consistency and quality of addiction treatment, now constitute a major barrier to shifting to more recovery-oriented systems of care. When programs embracing the RM philosophy seek to admit families rather than individuals, create multi-agency service teams that include indigenous institutions and cultural healers, utilize long-term recovery plans rather than short-term treatment plans, incorporate peer-based recovery support roles/teams, develop non-clinical recovery support systems in local communities, and provide long-term monitoring and early re-intervention services, they find themselves facing almost insurmountable fiscal and regulatory barriers. It is tragic and ironic that the major challenges of recovery management are posed, not by the complex needs of individuals and families seeking recovery, but by the systems originally set up to help facilitate that recovery. The mainstream implementation of recovery management will require a major overhaul of the reimbursement and regulatory systems governing addiction treatment. States like Connecticut that have begun this overhaul process are making a significant contribution to the future of addiction treatment and recovery in America (http://www.dmhas.state.ct.us/recovery.htm).

Slowing the development and implementation of RM models are the weak organizational infrastructures and high staff turnover rates that pervade the world of addiction treatment (McLellan, Carise, & Kleber, 2003). RM is founded on the continuity of relationship between an organization and the communities it serves and the capacity for sustained continuity of contact between each organization's front-line service professionals and the individuals and families within those communities who suffer from severe and persistent AOD problems. If there is an Achilles heel of the RM model, it is in the combined effects of organizational instability and staff turnover within the addictions field (Roman, Blum, Johnson, & Neal, 2002). If the process of RM is to parallel that of the long-term relationship between a primary care physician and a patient/family impacted by a chronic disease, that instability and turnover must be reversed.

The lack of a science-based understanding of long-term recovery constitutes a significant obstacle to the design of RM programs. As a field, our scientific knowledge about addiction and brief models of treatment has grown exponentially in recent decades, but our science has yet to connect the problem and the intervention to the process of long-term recovery. We know comparatively little from the standpoint of science about the prevalence, pathways, and styles of long-term recovery. The ability to find potent combinations and sequences of professionally directed treatment interventions and peer-based

recovery support services rests on the emergence of a recovery research agenda at the federal level. Without scientific data, RM pioneers will lack a reliable compass to navigate the recovery frontier.

A fifth obstacle in implementing RM models of care involves the integration of professional-directed treatment services and peer-based recovery support services (particularly within the newly emerging role of recovery coach). Questions abound related to such integration. Are recovery support services best provided by addiction treatment organizations or by free-standing recovery support and recovery advocacy organizations? Should recovery support services be added to the role of addiction counselor or segregated within a new specialized role? What are the best ways to recruit, train and supervise recovery support specialists? What are the boundaries of competence of these new recovery support specialist roles, and how do they fit into larger multidisciplinary teams? Which models of integrating or coordinating professional and peer-based recovery support services are associated with the best long-term recovery outcomes? Answers to such questions are crucial to the future evolution of the RM model, and their absence constitutes a major implementation obstacle.

The service capacity of an organization or service professional within the RM model has yet to be clearly defined. If, for example, an addiction counselor is responsible for providing ongoing monitoring and support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention services for those leaving traditional inpatient or outpatient treatment, what is a reasonable caseload for such a counselor? The answer is that we do not know. RM will require a significant reallocation of resources — a shift that will de-emphasize expensive, high-intensity acute care and emphasize lower-intensity, lower-cost, and more enduring recovery support services. Service capacities for organizations and individual workers will have to be redefined in that transition.

The ethical guidelines that have guided addiction treatment agencies and addiction counselors for the past three decades grew out of the acute care service relationship and were closely modeled after the ethical guidelines for psychologists and social workers (e.g., discouragement or prohibition of self-disclosure, prohibition of all dual relationships, prohibition of gifts, etc.). These guidelines, which presupposed a short-term, expert-based fiduciary service relationship, do not easily fit the less hierarchical and more enduring service relationships that characterize the RM model. It is crucial that ethical standards evolve to guide the provision of professionally delivered and peer-based recovery support services. The lack of current ethical guidelines for recovery support services raises the ethical vulnerability of service organizations and service professionals.

## Potential Pitfalls

This three-part series on the recovery management model of addiction treatment and recovery support would be incomplete without an exploration of some of the potential pitfalls of the RM model. Experience to-date suggests three potential pitfalls beyond the implementation challenges noted above.

Not everyone with an AOD-related problem needs RM services. Many individuals with such problems will resolve these problems on their own or will do so through mutual aid or brief professional intervention. Misapplying an RM model to persons with low problem severity and high recovery capital could generate iatrogenic effects within the RM model. Such misapplication could injure persons with transient AOD problems by inappropriately attaching a stigma-laden diagnosis and delivering services that are ineffective, a financial burden, and potentially harmful.

The emphasis on addiction as a chronic disorder within the RM model could inadvertently contribute to cultural pessimism about the resolution of AOD problems and heighten the stigma and discrimination attached to those problems (Brown, 1998). To counter such effects, RM models must constantly emphasize the reality of full recovery in the lives of millions of people who have suffered from severe and prolonged AOD problems.

The 1980s witnessed a period of institutional profiteering in which persons with alcohol and other drug problems were viewed as a crop to be harvested for financial profit. A too-rapid shift to RM models of reimbursement could unleash the same forces. Profiteers could garner large, capitated contracts for recovery support services, but then minimize the services delivered through such contracts to maximize institutional and personal profit. These profiteers could escape accountability for recovery outcomes behind the rhetoric that addiction is a chronic disease. To avoid this, RM models of reimbursement must include a high level of accountability for recovery outcomes. This will require clinical information systems that can track clinical outcomes and other performance indicators across multiple episodes of care.

Attempts to shift addiction treatment from a revolving emergency room door (via unending cycles of brief intervention) to a model of sustained recovery management face many implementation obstacles and potential pitfalls. These obstacles and pitfalls are offset by the potential of the RM model to align the design of addiction treatment with the growing body of scientific evidence documenting the chronicity of severe AOD problems and the complexity of long-term recovery. That potential and what it means for millions of people suffering from addiction will inspire many addiction professionals and addiction treatment organizations to experiment with this fundamental redesign of addiction treatment.

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# Recovery Management and People of Color:

## Redesigning Addiction Treatment for Historically Disempowered Communities.

William L, White, MA and Mark Sanders, LCSW, CADC

**Abstract**

*Communities of color have been ill-served by acute care models of treating severe alcohol and other drug (AOD) problems that define the source of these problems in idiopathic (biopsychological) terms and promote their resolution via crisis-elicited episodes of brief, individual interventions. This article explores how approaches that shift the model of intervention from acute care (AC) of individuals to a sustained recovery management (RM) partnership with individuals, families, and communities may be particularly viable for historically disempowered peoples. The advantages of the RM model for communities of color include: a broadened perspective on the etiological roots of AOD problems (including historical/cultural trauma); a focus on building vibrant cultures of recovery within which individual recoveries can be anchored and nourished; a proactive, hope-based approach to recovery engagement; the inclusion of indigenous healers and institutions with the RM team; an expanded menu of recovery support services; culturally grounded catalytic metaphors and rituals; and a culturally nuanced approach to research and evaluation.*

**Introduction**

Addiction has been characterized as a "chronic, progressive disease" for more than 200 years (White, 2000a), but interventions into severe alcohol and other drug (AOD) problems continue to be based on serial episodes of self-encapsulated, acute intervention (O'Brien & McLellan, 1996; Kaplan, 1997). Recent research has confirmed the chronic nature of severe AOD problems (Simpson, Joe, & Lehman, 1986; Hser, Anglin, Grella, Longshore, & Pendergast, 1997) and compared such problems to other chronic health disorders (e.g., type 2 diabetes mellitus, hypertension, and asthma) in terms of their etiological complexity, variability of course, and recovery and relapse rates (McLellan, Lewis, O'Brien, & Kleber, 2000). Calls for shifting addiction treatment from an acute care (AC) model to a model of sustained recovery management (RM) are increasing (White, Boyle, & Loveland, 2002, 2003; Compton, Glantz, & Delaney, 2003; Edwards, Davis, and Savva, 2003; Moore & Budney, 2003), and components of such models are currently being evaluated with adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002) and adults (Dennis, Scott & Funk, 2003). The emerging model of recovery management has been defined as:

> *…the stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a time-sustained, recovery-focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe*

*behavioral health disorders until full remission has been achieved or until recovery maintenance can be self-managed by the individual and his or her family* (White, Boyle, Loveland and Corrigan, 2003).

This article contrasts the application of AC and RM models of intervention into severe AOD problems within communities of color[1]. We will focus specifically on those American Indian/Alaskan Native[2], African American, Hispanic/Latino, and Asian and Pacific Islander communities whose members present unique challenges and resources as they enter publicly funded treatment for severe AOD problems. Our contrast of AC and RM models is drawn from the pioneering work of McLellan, Lewis, O'Brien, and Kleber (2000) and from the descriptions of the RM model set forth by White, Boyle, and Loveland (2002, 2003). We argue that historically disempowered persons, and, in particular, communities of color, have been ill-served by acute, biomedical models of intervention into AOD problems, and that models of recovery management hold great promise in providing more effective solutions to AOD problems within communities of color. We will explore elements of RM that tap deep historical traditions within communities of color and that are highly congruent with contemporary, abstinence-based religious and cultural revitalization movements within communities of color.

Great care must be taken that discussions of the needs of ethnic communities do not inadvertently contribute to stereotypes about communities of color. To determine whether RM models of intervention hold greater promise than AC models within communities of color, we will need to explore those characteristics of communities of color that have relevance to the viability of these models. Given the enormous differences within and between ethnic communities and the changes in communities over time, we would ask readers to keep all observations, ideas, and strategies set forth in this article on probation pending their validation within particular communities and with particular individuals and families. "People of color" and "communities of color" do not constitute a monolithic group to which any single explanatory or intervention model can be indiscriminately applied. We also recognize that the concepts set forth here may not be limited to communities of color and may also apply to particular white communities. Testing of components of the RM model will need to be conducted in all ethnic communities and across multiple subpopulations within those communities. To achieve this will require redesigning addiction treatment in light of new recovery management models and doing this within the larger framework of cultural competence.[3] We hope this introductory paper will stand as an invitation for such sustained exploration. Our vision is the development of culturally competent models of recovery management within all communities and the dynamic evolution of RM principles and practices based on experience within and dialogue between communities.

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[1] While we have limited our discussion to communities of color, many reviewers (including Hennessey and Simonelli) of early drafts of this paper were struck by how applicable the ideas and strategies set forth in this paper are to women of all ethnic backgrouds.

[2] All future references to American Indians or Native Peoples are intended to include Alaskan Natives.

[3] Culltural competence has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance. Center.

We will begin by contrasting how AC and RM models conceptualize the sources and solutions to AOD problems and then explore the RM model's emphasis on proactive engagement, the use of indigenous healers and institutions, catalytic rituals and metaphors, new technologies of monitoring and recovery support, a sustained recovery management partnership, and the need for culturally nuanced approaches to recovery research and evaluation.

## AC and RM Models: The Source of AOD Problems

> *American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon…contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism and other social problems among American Indians.*
>
> — Brave Heart & DeBruyn, 1998

> *When people are taught to hate themselves, they will do bad things to themselves.*
>
> — Sanders, 1993.

Acute care (AC) models of intervention have assumed that the sources of and solutions to AOD problems reside within the individual, and that brief interventions to alter an individual's physical, cognitive, and emotional vulnerabilities can produce a permanent resolution of these problems. When the AC model fails to resolve AOD problems, the root of that failure is viewed as residing inside the individual. The professional response, in practice if not in theory, is to prescribe additional repetitions of the failed intervention. Of people admitted to publicly funded addiction treatment in the U.S., 60% have been in treatment before (including 23% 1 time, 13% 2 times, 7% 3 times, 4% 4 times, and 13% 5 or more times) (OAS, 2000). An aggressive system of managed behavioral health care has lowered the intensity and duration of these treatment episodes, further lessening the viability of addiction treatment for persons within communities of color who present with high problem severity and chronicity. Awareness of this inadequacy has triggered the rise of indigenous recovery movements, including the Wellbriety Movement in Indian Country (see www.whitebison.org) and Afrocentric frameworks of recovery, e.g., faith-based recovery ministries (Glide Memorial Church, One Church — One Addict, Free N' One, African American Survivors Organization, Turning Point) (Sanders, 2002). Recovery within these movements is seen, not as a singular goal, but as a therapeutic byproduct of participation in larger cultural and religious revitalization processes.

The premises of the RM model contrast sharply with those of the AC model. RM models posit that AOD problems spring from multiple, interacting etiologies; unfold (suddenly or progressively) in highly variable patterns; ebb (remission) and flow (relapse) in intensity over time; and are resolved at different levels (from full to partial) via multiple long-term pathways of recovery. This opening proposition has particular relevance to communities of color. It suggests that people of color may be at risk for AOD problems but that these risk factors differ between and within ethnic groups (Matsuyoshi, 2001). It suggests that historical, political, economic, and socio-cultural circumstances can also serve as etiological agents in the rise of AOD problems. Client discussions about cultural pain (e.g.,

slavery, the loss of land, attempted extermination, epidemic diseases, the purposeful break-up of tribes and families, the loss of families and culture via immigration or forced deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism, and discrimination) are viewed, not as defocusing or acting out, but as a medium of a consciousness raising and catharsis that can open doorways to personal and community healing and transformation (Green, 1995). This approach is much more congruent with beliefs within communities of color that their AOD problems result as much from historical trauma[4], economic and political disempowerment, and cultural demoralization as from biological vulnerability (Manson, 1996; Brave Heart & DeBruyn, 1998; Brave Heart, 2003). This view recognizes that historical trauma and cultural oppression elevate risk factors for substance use problems and erode resiliency factors that operate as a protective shield against AOD problems and speed their natural resolution (Brave Heart, 2003). Culturally nuanced models of RM reflect an understanding of the effects of intergenerational trauma (grief, rage, self-hatred, self-medication) upon whole communities. Positing multiple pathways of long-term recovery also opens up the potential for culturally prescribed frameworks of AOD problem resolution (abstinence-based religious and cultural revitalization movements, e.g., Nation of Islam) as well as cultural adaptations of existing recovery support structures (e.g., the "Indianization" of Alcoholics Anonymous and the adaptation of A.A. within Hispanic/Latino communities) (Womak, 1996; Hoffman, 1994).

RM models assume that severe AOD problems constitute complex, chronic disorders that require sustained individual, family, community, and cultural interventions for their long-term resolution. In this view, treating severe and persistent AOD problems via AC models of intervention is as ineffective as treating a bacterial infection with half the effective dose of antibiotics. While providing temporary symptom suppression, such treatment results in the subsequent return of the problem, often in a more virulent and treatment-resistant form. In the RM model, the treatment of severe and persistent AOD problems is best done within a sustained recovery management partnership that provides ongoing recovery support and consultation and anchors the recovery process in indigenous supports within the client's natural environment.

Chronic disorders such as diabetes and heart disease take an undue toll on communities of color, but substantial efforts are underway within communities of color for the prevention, early intervention, and sustained management of such chronic health problems. People of color are learning that the successful management of these disorders requires an understanding of:

- personal/family vulnerability;
- the influence of environmental conditions on the ebb and flow of these disorders;
- the propensity for these disorders to generate collateral health and family problems; and

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[4] Maria Yellow Horse Brave Heart (2003) has defined historical trauma as "cumulative emotional and psychological wounding over the lifespan and generations, emanating from massive group trauma experiences."

- the role of daily lifestyle decisions (eating, sleeping, exercise, etc), and the need for sustained self-vigilance, in the management of these disorders.

As communities of color learn more about the nature and treatment of chronic primary health disorders, that knowledge base can be extended to severe AOD problems. There is already some recognition of addiction as a chronic disorder via people of color sustaining hope for a family member or friend's recovery, long after the rest of the world has lost such hope. That capacity for patience, compassion, and forgiveness is not a sign of pathology (codependency), but an unheralded resource of hope and support within communities of color upon which the RM model seeks to build.

The acute model rests on the assumption that AOD problems are self-contained and that individuals have the internal and external resources to sustain recovery and assume full social functioning following detoxification and brief treatment. It assumes a foundation of pre-morbid skills and social functioning. This rehabilitation model promises the client that he or she will regain prior levels of functioning and status lost via the accelerating severity of AOD problems. This model is poorly suited to individuals who have not achieved such prior levels of successful functioning and who have no significant support for recovery within their family and social networks. The model is particularly unsuited to those poor communities of color whose members often present with high AOD problem severity, numerous co-occurring problems, and low "recovery capital" (internal and external resources that help to initiate and maintain recovery) (Granfield and Cloud, 1999).

In contrast, the RM model assumes that clients have widely varying degrees of problem severity and recovery capital and that the degree and duration of need for recovery support services requires differential allocation of services across these levels of functioning. Where levels of care within traditional treatment are dictated primarily by problem severity, RM models set service intensities and duration based on the unique interaction of problem severity and recovery capital. For example, the African American business executive with high AOD problem severity but high recovery capital would be viewed as needing less intensive and sustained recovery support than an African American adolescent with low AOD problem severity but with many co-occurring problems and low recovery capital. For those with little recovery capital, RM provides a framework for sustained habilitation.[5] The RM shift in emphasis is from recovery initiation to recovery maintenance (the movement toward global physical and emotional health; a reconstruction of personal identity and interpersonal relationships; and the development of a recovery-based, pro-social lifestyle). This habilitation emphasis is one of the driving forces behind the expanded menu of recovery support services (described below). This same habilitation emphasis is also extended to the families and communities within which AOD problems are enmeshed.

## The RM Solution: Personal, Family, and Community Renewal

*Ultimately, it is the community that cures....To cure the wounded, one need only*

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[5] Rehabilitation assumes the existence of and need for replemishment of recovery capital; habilitation assumes the lack of pre-existing recovery capital and the need to dramatically reconstruct personal identity, interpersonal relationships, and a sobriety-based lifestyle.

*return them to their community or construct a new one.*
— Philip Rieff, 1987

*Community healing along with individual and family healing are necessary to thoroughly address historical unresolved grief and its present manifestations.*
— Brave Heart & DeBruyn, 1998

The unit of service within the AC model is the individual with an AOD problem. Professional interventions are designed to lower the biological vulnerability and alter the beliefs and behaviors thought to sustain addiction. Within the RM model, individuals with AOD problems are viewed as being nested within a complex web of family, social, and cultural relationships. Each level of this social ecosystem can contribute to the development of, help resolve, or sabotage the solution of these problems. As a result, it is the whole ecosystem rather than the individual that is the target of the RM intervention. RM moves beyond the clinical skills of assessment, diagnosis, and treatment of individuals to encompass the skills of family reconstruction, community resource development, and nation-building (see the work of White Bison for examples of the latter).[6] RM in communities of color is premised on the belief that the community — experienced through group solidarity with a historical and geographical community — is an essential dimension of personal healing (Murphy, Personal Communication).

In the AC model, the family is a stimulus for help-seeking, a source of emotional and financial support for treatment retention, and a target for brief education and referral to peer-support (e.g., Al-Anon). The assumption is that whatever wounds the family suffered through the addiction experience will naturally and quickly reverse themselves following the addicted family member's recovery initiation. In contrast, the RM model assumes the following:

- Addiction is but one wound families of color have suffered via the intergenerational transmission of historical trauma (e.g., the forced breakup of family units in slavery, the Indian boarding schools and their prolonged aftermath, traumatic separation via immigration), and the family unit itself needs a sustained process of recovery from these wounds (Brave Heart & DeBruyn, 1998).

- The addiction-related transformation of family roles, relationships, rules, and rituals is deeply imbedded within family members and habitual patterns of family interaction and will not spontaneously remit with recovery initiation.

- There are developmental stages of family recovery that entail personal healing, a realignment of family subsystems (adult intimate relationships, parent-child relationships, and sibling relationships), and the family's relationship with the outside environment — tasks that consume the first 3-5 years of stable recovery (See Brown, 1994; Brown & Lewis, 2002).

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[6] Nation-building as used here refers to the process of linking the disempowered community into a larger cosciousness and identity and a process of healing that seeks to heal historically disempowered communities AND the dominant culture of which they are such integral parts. One of our reviewers (Simonelli) called this "the next frontier of healing."

- Families who do not have sufficient supports to make these difficult transitions are at high risk for disintegration — in spite of their having remained intact through years of addiction (Brown & Lewis, 2002).

- Sustained recovery monitoring and support for family members is as crucial as it is for the individual recovering from severe AOD problems.

- RM services for families must be refined based on the unique family and kinship patterns that exist within particular ethnic communities.

A major focus of RM is to create the physical, psychological, and social space within local communities in which recovery can flourish. The ultimate goal is not to create larger treatment organizations, but to expand each community's natural recovery support resources. The RM focus on the community and the relationship between the individual and the community are illustrated by such activities as:

- initiating or expanding local community recovery resources, e.g., working with A.A./N.A. Intergroup and service structures (Hospital and Institution Committees) to expand meetings and other service activities; African American churches "adopting" recovering inmates returning from prison and creating community outreach teams;

- educating contemporary recovery support communities about the history of such structures within their own cultures, e.g., Native American recovery "Circles," the Danshukai in Japan;

- introducing individuals and families to local communities of recovery;

- resolving environmental obstacles to recovery;

- conducting recovery-focused family and community education;

- advocating pro-recovery social policies at local, state, and national levels;

- seeding local communities with visible recovery role models;

- recognizing and utilizing cultural frameworks of recovery, e.g., the Southeast Asian community in Chicago training and utilizing monks to provide post-treatment recovery support services; and

- advocating for recovery community representation within AOD-related policy and planning venues.

The importance of community in understanding AOD problems within communities of color is perhaps most evident within the rising Wellbriety movement in Indian Country. A central idea within this movement is the "Healing Forest" metaphor developed by Don Coyhis (1999). In Coyhis' work, the AC model of treatment is analogous to removing a sick tree from diseased soil, nursing it back to health in well fertilized and well watered soil, and then returning it to the diseased soil from which it came. Coyhis suggests that

we would need fewer tree hospitals if we treated the trees AND the soil in which the trees suffer or thrive. He calls for the creation of a "healing forest" to nurture sobriety and wellness. This broader vision of creating healthy communities that resist AOD problems and within which recovery can thrive is pervasive in communities of color but is markedly absent within the professional field of addiction treatment.

In communities of color, the individual, the family, and the community are inseparable. To wound one is to wound the other; to heal one is to heal all (Red Road to Wellbriety, 2002). When asked how the Shuswap tribe in Alkali Lake, British Columbia successfully reduced its alcoholism rate from nearly 100% to less than 5%, Chief Andy Chelsea declared simply, "the community is the treatment center" (quoted in Abbot, 1998; See also Chelsea and Chelsea, 1985 and Taylor, 1987). Frameworks of recovery within communities of color have always been, and continue to be, defined in terms of an inextricable link between hope for the individual and hope for a community and a people. The most effective and enduring solutions to AOD problems among people of color are ones that emerge from within the very heart of communities of color. The RM model seeks to tap this vein of resistance and resilience by recognizing and enhancing the recovery support capacities of families, kinship networks, indigenous institutions (e.g., mutual aid groups, churches, clans), and whole communities and tribes. The focus of RM interventions is not restricted to the individual, the family, or the community, but is focused on all levels of this recovery ecosystem and their inter-relationships.

### Proactive Engagement

> *My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.*
>
> — Outreach Worker (Quoted in White, Woll, & Webber, 2003)

The AC model of intervention is essentially crisis oriented. It relies on internal pain or external coercion to bring individuals to treatment, and places the responsibility for motivation for change squarely and solely on the individual. It assumes that people move from addiction to recovery when the pain of the former state reaches a point of critical mass. The AC model is also characterized by a high threshold of engagement (extensive admission criteria and procedures), high rates of client disengagement (terminating services against staff advice) and high rates of client extrusion ("administrative discharge" for noncompliance). In contrast, the RM model is characterized by assertive models of community outreach, pre-treatment recovery support services, and the resolution of personal and environmental obstacles to recovery. Motivation for recovery is not assumed to be static — a dichotomous ("you have it or you don't") entity — but is an entity that emerges out of and is sustained by an empowering service relationship. It is assumed that such motivation waxes and wanes and that active recovery coaching can help the client transcend periods of heightened ambivalence, diminished confidence, and recovery-induced anxiety. One of the earliest examples of such proactive outreach was the work of the East Harlem Protestant Parish among New York City's Puerto Rican heroin addicts in the 1950s. This faith-based program recruited addicts from the streets and enmeshed them within pro-recovery social clubs and a larger religious community within which they were

welcomed and respected (White, 1998).

The proactive engagement of the RM model is particularly suited for individuals whose personal/cultural experiences have engendered an exceptionally high physical and emotional tolerance for pain, and for those who have never known anyone in recovery. Proactive engagement is also important for people of color who:

- lack the knowledge, skills, and financial resources required to navigate complex health and human service systems;
- fear bringing shame to their families (losing "face") by breaking prohibitions on disclosing personal problems outside the family and/or kinship network — shame dramatically enhanced for women;
- have had negative experiences within or distrust formal service systems;
- bring special obstacles to accessing services (e.g., language barriers, undocumented status); and
- possess beliefs about illness and health that conflict with the explanatory metaphors of mainstream service systems.

The RM model of engagement is particularly well suited for people of color whose resistance to treatment flows from the inertia of hopelessness. Where AC models are most effective with individuals ready to take action related to their problems, RM models place great emphasis on the pre-action stages of change and the long-term maintenance stages of change (See Prochaska, DiClemente, & Norcross, 1992 and Prochaska, Norcross, & DiClemente, 1994 for a description of the stages of change)[7]. The model assumes that the scales of long-term recovery are tipped, not by the sobriety decision (alcoholics/addicts make many such decisions), but by the interaction of what precedes and follows such decisions.

Of all the obstacles that proactive engagement is designed to address, perhaps the most difficult in both AC and RM models is the issue of language. Key informants from many ethnic communities emphasized the need for more bilingual professionals and service volunteers. This language barrier will have to be overcome if RM models are to fulfill their potential within ethnic communities. The outreach and assertive continuing care functions, in particular, will require a high level of cultural and linguistic fluency. The RM emphasis on building service capacity within communities offers some hope for expanding such competence.

While this assertive model of engaging and supporting individuals through the stages of

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[7] Research on developmental stages of change is in its infancy, and the emerging models tend to portray recovery for individuals and families in very linear terms. We suspect, and thank Tom Murphy for reminding us, that these processes are much more dynamic than what is conveyed in a linear, four-to-five-step model. Recovery, particularly for historically disempowered people, may be much more comparable to the subtle patterns and surprise-revealing pathways of a Japanese garden than that of a ladder.

recovery is well suited to the obstacles and complex needs presented by many people of color, great care will have to be taken with this aspect of the RM model. The values of benevolence, generosity, and service co-exist with the value of noninterference in the affairs of others within communities of color. The implementation of RM models in communities of color will require considerable care to avoid violating this latter value. The key will be to use RM's assertive approach to engagement and post-treatment monitoring and support, but to do so only with the continuing consent of the community, family, and individual client.

Another dimension of the RM model (emerging from its view of multiple pathways of recovery) is its respect for the power and legitimacy of transformative change as a medium of recovery initiation (Miller & C'de Baca, 2001)[8]. Non-ordinary experiences (e.g., dreams, visions, climactic conversions) have long marked a pathway of addiction recovery for people of color, particularly among those who have led religious and cultural revitalization movements (e.g., Handsome Lake, Malcolm X). In contrast to the conversion style of induction, recovery may also be marked by a reaffirmation and deepening of existing religious/spiritual beliefs and practices, as Morjaria and Orford (2002) found in their study of South Asian American men (see also Manik et al., 1997). Where traditional AC models of treatment tend to discount the power and durability of religious experiences and the role of religious institutions as viable sobriety-based support structures, the RM model celebrates the legitimacy of these experiences and support institutions. It is clear that sustained sobriety can be a byproduct of religious and cultural affiliation and a heightened ethnic identity, whether this occurs within the Nation of Islam, the Indian Shaker Church, or a Buddhist or Hindu Temple. Such recoveries involve not just a redefinition of personal identity, but also a redefinition of oneself as an Indian, African American, Latino, or Asian person. For example, Spicer's studies of recovery in Native American communities found that recovery initiation was associated with heightened Indian identity and the incompatibility between drinking and emerging beliefs about how Indian people should conduct their lives (Spicer, 2001). This recognition of the power of culturally mediated transformative change provides a foundation of respect upon which RM-based organizations can collaborate with religious and cultural revitalization movements within communities of color.

### Indigenous Healers/Institutions and the Recovery Management Team

> *Many individuals maintain sobriety only after they resume or begin regular involvement in traditional spiritual practices*.
>
> — Brave Heart & DeBruyn, 1998

> *The persistence and revival of indigenous Amerindian healing is due not to a lack of modern treatment services, but to a need for culture-congenial and holistic therapeutic approaches.*
>
> — Jilek, 1978

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[8] Miller and C'de Baca describe transformative change as dramatic alterations of personal identity and character that are "vivid, surprising, benevolent and enduring." (p.4).

The AC service approach is based on the recognition of AOD problems as a biopsychosocial disorder. As a result, AC treatment interventions are delivered by an interdisciplinary team of physicians, nurses, psychologists, social workers, and addiction counselors. In contrast, the RM model recognizes other dimensions of AOD problems (e.g., economic, political, cultural, spiritual, religious) and broadens the recovery management team to include indigenous community institutions and healers. People of color utilize cultural healing therapies as alternatives or adjuncts to mainstream medicine and psychiatry, with the majority not reporting visits to alternative practitioners to their mainstream service providers (Keegan, 1996). Studies of the course of alcohol problems among American Indians have found remission/recovery rates as high as 60%, with few such recoveries attributable to formal alcoholism treatment (See Spicer, 2001 for a review). American Indians have a long history of abstinence-based religious and cultural revitalization movements, indigenous healers as mediums of alcoholism recovery, and the use of Native medicines and ceremonies as adjunctive supports for recovery (White, 2000b; Coyhis & White, 2002). Growing awareness of this history has spurred calls for culture-congenial therapeutic approaches via an integration of Western treatment methods and traditional Native American healing practices (Jilek, 1974; Weibel-Orlando, 1987; and Westermeyer, 1996). There is similar evidence for indigenous recovery frameworks in the Hispanic/Latino (Thomas, 1967; Singer & Borrero, 1984; Núñez Molina, 2001), Asian (Das, 1987; Yamashiro, & Matsuoka, 1997) and African-American communities (Leong, Wagner, & Tata, 1995). These indigenous recovery frameworks place great emphasis on the healing power of *regalos* — cultural values and ceremonies. Where traditional treatment programs question the viability and durability of these cultural and religious pathways of recovery (in practice if not in theory), the RM model is open to the inclusion of such institutions and their representatives within the recovery management team. In the RM model, the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist may each play a role within the RM team.

A recent evaluation of gender-specific addiction treatment programs in Illinois found that a significant number of recovering and recovered[9] African-American women are using the Black Church as their primary sobriety-based support structure, but most do so only months after initiating recovery and addressing issues of shame related to their addiction (White, Woll, & Webber, 2003)[10]. Similar documentation exists on the use of religious frameworks of addiction recovery in other communities of color (Núñez Molina, 2001; Coyhis & White, forthcoming). This raises an interesting point about the differences between the ways in which individuals initiate recovery and the ways in which they sustain that recovery over time. More specifically, it suggests that some clients of color may use one institution to initiate recovery (e.g., professionally directed treatment, Alcoholics Anonymous, or Narcotics Anonymous), but use culturally indigenous institutions to sustain recovery (e.g., the Black Church). Failure to sustain recovery could thus be viewed, not as a need for more recovery initiation services (the AC treatment model), but as a need to find a cultural pathway of long-term recovery maintenance (the RM model).

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[9] See White, 2002 for a discussion of the distinction between *recovered* and *recovering*.

[10] The source of that shame transcends self-perceived sins of omission and commission and reaches to the very core of their identities as women and as African-American women.

The RM model assembles professional and indigenous service teams to meet the unique recovery support needs of each client and family. The rationales for the use of such non-traditional teams are to expand the recovery support services available to individual clients and to decrease the number of people needing professional services by expanding natural recovery supports within the larger community. The inclusion of indigenous healers and recovery support institutions rests on a simple assumption: the natural community is an oasis of human and spiritual resources that can be tapped to resolve personal and family problems (McKnight, 1995). In the RM model, the centerpiece of recovery is not the treatment institution, but the client and his or her relationship to this larger community.

The inclusion of non-traditional roles within the RM service team raises the question of credibility and credentialing of service providers within communities of color. Credibility bestowed from the dominant culture has value within communities of color only when the individual with such credentials is further vetted inside the community. This is typified by the concepts of *respeto*, *personalismo*, *dignidad*, and *confianza* within Hispanic/Latino communities — concepts that dictate respect based on personhood rather than financial or occupational status (Soriana, 1995). Credibility in communities of color is more likely to be bestowed upon those with nonjudgmental attitudes, knowledge of the culture, and demonstrated resourcefulness and effectiveness (Sue & Sue, 1999).

Credibility as a healer inside communities of color requires two things: *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge requires wisdom gained about a problem from close up — first-hand versus second-hand knowledge. 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 effect 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 living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes, not from their preparation, but from their character, relationships, and performance within the community. RM models capitalize on such experiential expertise by recruiting indigenous healers as legitimate members of recovery management teams, e.g., outreach workers, recovery coaches, and culturally grounded therapists/nurses/physicians.

RM also turns those seeking help into sources of support for others via their involvement in mutual support groups, peer-based service models, and recovery advocacy organizations. Within communities of color, there is a long history of the concept of "wounded healer" (the idea that surviving a life-threatening illness or experience bestows knowledge and an obligation to help others facing this illness or experience), and a tradition of helpers credentialed by "calling" (White, 2000b). By transforming the process of recovery from an interaction between a professional and a patient to reciprocal support among

members of a community of recovering and recovered people, RM taps this wounded healer tradition and utilizes what has been christened the "helper-therapy principle" (the therapeutic effects of helping others) (Reissman, 1990, 1965). Converting service recipients into service dispensers exponentially expands indigenous recovery resources within communities of color. Reaching out to the suffering alcoholic/addict has been espoused by leaders of American recovery communities, from the Washingtonian mantra, "You've been saved, now save another" (White, 1998) to what Malcolm X referred to as "fishing for the dead" (Myers, 1993, p. 82). With its emphasis on transforming people who have been part of the problem into part of the solution, RM creates a cadre of people whose living example and recovery advocacy activities can help neutralize the particularly intense stigma that has long been attached to addiction in communities of color.

### People of Color and the Criminal Justice and Child Welfare Systems

People of color, particularly African Americans, are over-represented within America's criminal justice and child welfare systems. Constituting only 12.1% of the U.S. population (U.S. Census Bureau, 2000) and 15% of illicit drug consumers (SAMHSA, 1998), African Americans constitute 56.7% of those currently in state prison on drug offenses (Harrison & Beck, 2003). Studies have also shown that race plays an important role in involvement in child protection services. Although rates of drug use during pregnancy are nearly identical for African American and White women, African American women are ten times more likely to be reported to child protection authorities for prenatal drug exposure (Neuspiel, 1996; Chasnoff, Landress, & Barret, 1990). Any intervention into alcohol and other drug problems in communities of color must recognize the dominant role of the criminal justice and child welfare systems as treatment referral sources.

The AC model of intervention is strongly linked to these systems, and that is in itself a problem. People of color with high problem severity and complexity (e.g., multiple problems) continue to be routinely placed in brief interventions that have little chance of success, and then are punished (via incarceration or loss of custody of children) when those failed outcomes occur, on the grounds that "they had their chance." The financially motivated collaboration of the treatment system in this process is altering the perception of treatment institutions from institutions of service and care to institutions of coercion and control. Masked behind euphemisms such as "treatment works" is the story of how addiction treatment programs have become an extension of the criminal justice and child protection systems within communities of color. We would argue that it is not enough to deflect people of color into treatment as an alternative to incarceration or family disintegration. The treatment received must be designed in such a way as to offer a realistic chance of success. Punishing people with high problem severity for failing to achieve sustained abstinence following treatment within an AC model is part of a long history of "blaming the victim" within communities of color.

It remains to be seen whether RM models will offer a more viable option for people of color involved in the criminal justice and child welfare systems, but RM models do have several characteristics that make success more likely. First, the longer duration of service contact in the RM model is more realistic and constitutes more of a real "chance" than treatment based on the AC model. The RM emphasis on engagement and sus-

tained monitoring and support is very congruent with such criminal justice initiatives as intensive probation, drug courts, and sentence circles. It is also congruent with the gender-specific addiction treatment models emerging within the child welfare system (White, Woll, & Webber, 2003). What RM may contribute is the birth of collaborative models that combine the surveillance functions of the criminal justice and child protection systems with sustained mechanism of recovery support and early re-intervention. Such models could span a continuum of intervention points from diversion programs to community re-entry from prison. More effective systems of intervention and support could decrease the number of people entering, and widen the doorways of exit from, the criminal justice and child protection systems. RM models could be built on the peer-based engagement and support models that have been used to reach addicted people of color within the CJ system, e.g., the Nation of Islam, Winner's Circle.

### Expanded Menu of Services and Catalytic Metaphors

> *Metaphors are culturally-grounded figures of speech that in their subtlety, complexity and power strike deep emotional cords that ignite processes of personal transformation.*
>
> — White & Chaney, 1993

> *…transformations of the self and its relationship to core symbols in a particular cultural system of meaning appear to lie at the heart of how people are restored to wholeness following their problematic involvements with alcohol.*
>
> — Spicer, 2001

The AC model of addiction treatment is based on the development of "programs" (a prescribed combination and sequence of therapeutic activities) that clients experience with minimal variation. Program activities and protocols focus on detoxification, problem stabilization, and recovery initiation. RM models, by placing equal or greater emphasis on pre-treatment engagement and post-treatment recovery maintenance, expand the service menu considerably and, in the process, redefine the very identity of treatment institutions.

The RM service menu is based on three premises:

1. People with AOD problems represent multiple clinical subpopulations with diverse needs: the effectiveness of treatment and support services varies considerably across clinical subpopulations and individuals within these subgroups.

2. There are developmental stages of long-term recovery: the same individual may need different treatment and support services at different stages of his or her addiction and recovery careers.

3. There are qualitative differences between AOD problems and the processes used in their resolution within communities of color.

RM replaces the treatment "program" with a large menu of service and support activities that are uniquely combined and supplemented to meet the stage-dependent needs of

people in recovery. In this model, the service menu is constructed using frameworks of healing drawn first from the client's own cultural background, e.g., the use of specialized therapies such as the Japanese psychotherapeutic approach known as *Naikan,* in which the patient is sequestered for self-reflection on his or her character and relationships under the guidance of periodic visits from the therapist (*sinsei*) (Das, 1987). RM seeks to initiate and sustain recovery within the framework of cultural values using methods that markedly differ from client to client (See Flores, 1985-86). The shift toward a multicultural menu of values and service activities requires a high degree of individualization and a more sophisticated, comprehensive knowledge of the personal, intracultural, and transcultural processes of long-term recovery.

RM proponents are also interested in the kinds of words, ideas, metaphors, and rituals that initiate and strengthen recovery, mark the shift from one stage of recovery to the next, and sustain recovery over a prolonged period of time. This interest is congruent with the belief in the power of words (speeches, sermons, and stories) and healing ceremonies within communities of color. The following assumptions describe the potential role of words, ideas, metaphors, and rituals in the addiction recovery process.

1. Words, ideas, metaphors, and rituals can exert an enslaving or liberating effect on one's relationships with alcohol and other drugs (White & Chaney, 1993; White, 1996).

2. Words, ideas, metaphors, and rituals that serve as a catalyst for change in one person or cultural group may have no such power with other persons or cultural groups. There are specific ethnic/cultural worldviews, and the elements of these worldviews constitute the raw materials from which pathways of resilience to and recovery from AOD problems must be constructed (Taylor, 1992).

3. Catalytic metaphors[11] evolve and recycle within cultures over time. Their use as agents of transformation rests on their contemporary power; they must resonate within the present cultural and personal experience of the individual seeking recovery.

4. The growing phenomenon of biculturalism suggests that individuals may be able to combine or sequence metaphors from two or more cultures to initiate recovery or shift from one stage of recovery to the next.

5. Addiction treatment programs serving heterogeneous populations must provide a diverse menu of organizing words, ideas, metaphors, and rituals to widen the doorways of entry into recovery and support culturally mediated stages of long-term recovery (White, 1996).

The following observations reflect the ways in which words, ideas, metaphors, and rituals have been used by historically disempowered peoples to initiate and sustain recovery from addiction.

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[11] Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite beliefs, behavior, identity, and relationships.

1. During the peak period of contact and colonization, people of color are prohibited from drinking or provided only controlled opportunities for drinking (e.g., Slave Code prohibitions on drinking, Federal prohibition of the sale of alcohol to American Indians) and are targeted via drug prohibition laws (e.g., anti-opium ordinances aimed at Chinese immigrants, anti-cocaine laws aimed at African Americans, anti-peyote laws aimed at American Indians, and anti-marijuana laws aimed at Mexican immigrants) (See Musto, 1973; Helmer, 1975; Morgan, 1983).

2. Patterns of psychoactive drug use and their effects upon people of color are exaggerated or fabricated as part of a racial mythology that justifies colonization and cultural domination (e.g., Native American "firewater myths") (Coyhis & White, forthcoming; Morgan, 1983)

3. People of color, in their early struggles for liberation, use the consumption of alcohol and other drugs to cope with feelings of hopeless and to deal with historical trauma.

4. Political and religious leaders within communities of color subsequently link AOD use to historical oppression, portray alcohol and other drugs as weapons of continued colonization and domination of their communities (Tabor, 1970; Herd, 1985), and portray sobriety as an act of resistance and liberation (Douglas, 1855; Cheagle, 1969).

5. Recovery mutual aid movements arising out of historically disempowered people emphasize metaphors of resistance, emancipation, and power, e.g., "I have a problem that once had me" (Kirkpatrick, 1986), "I will take control of my life" (Williams & Laird, 1992).

6. Heightened consciousness of racial history and identity can be a pathway of entry into recovery, or it can be part of a process of discovery in the later stages of recovery (Green, 1995).

By recognizing multiple pathways and styles of long-term recovery, the RM model embraces and works within these alternative frameworks of recovery. It views tenets of belief about AOD problems and their resolution within their historical context and in terms of their utility for initiating or anchoring recovery. This requires considerable knowledge of indigenous cultures and fluency with prevailing cultural or religious metaphors that can incite or strengthen the process of addiction recovery. The viability of a particular metaphor for understanding AOD problems and ways in which they can be resolved varies widely between cultures and varies widely across individuals (e.g., by degree of acculturation). The question is not: Which explanatory metaphor is true? The question is: Which organizing metaphor, by explaining things that are otherwise inexplicable, serves as a catalyst for personal, family, and community healing? There are many people of color who have found recovery through mainstream treatment and recovery support organizations (e.g., A.A./N.A.), but there are also many people of color who have recovered from addictions who neither portray themselves as having suffered from the disease of alcoholism/addiction nor portray themselves today as alcoholics or addicts in recovery. They have found alternative rationales for sobriety and different metaphors to explain who they once were and who they are today (see Spicer, 2001).

There is no dominant organizing metaphor for recovery within the RM model. With its operational motto, "recovery by any means necessary, " the RM model is broad enough to embrace clients who talk about their addictions in terms of:

- disease and recovery,
- habit and choice,
- badness (crime) and reformation,
- sin (idolatry, demon-possessed) and redemption (God-touched),
- cursed (for breaking cultural taboos) and healed,
- excess and harmony (balance),
- shame and honor (face),
- genocide and personal/cultural survival, or
- messed up and worn out ("sick and tired of being sick and tired").

The goal of RM is not to impose an organizing metaphor for recovery, but to work within whatever metaphors individuals and families find most personally and culturally meaningful.

The same broad perspective applies to transformative rituals. Where the dominant AC models of intervention into AOD problems rely on rituals of getting into oneself (e.g., psychotherapy), RM models are open to other cultural frameworks of recovery that involve a process of getting out of oneself and relying on resources and relationships beyond the self. Where the former view recovery as a process of self-exploration, the latter recognize the potential of recovery initiation via processes of self-transcendence — a value much more congruent with the spiritual-focused and community-focused ethos of communities of color.

### Sustained Monitoring and Support

> *Chronic diseases require chronic cures*.
>
> — Kain, 1828

> *If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients.*
>
> — McLellan, 2002

Communities of color have become distrustful of promised quick fixes because so many of those promises have been betrayed. Professionals come and go; programs come and go; agencies come and go. Arguments over whether addiction treatment should consist

of five sessions or 25 sessions, five days or 30 days, cognitive or family therapy are all arguments inside the acute care model of admission, treatment, and discharge. The inherent brevity of acute interventions into complex, chronic problems is often experienced as superficial pacification, professional disinterest, and abandonment. People of color, who tend to enter addiction treatment at later stages of problem severity and with a greater number of co-occurring problems (Bell, 2002), are ill-served by service models whose low intensity and short duration offer little opportunity for success. At a practical level, the acute model provides few options: regular readmission for detoxification and respite, demoralization and a cessation of treatment-seeking, or a search for recovery maintenance outside the realm of professionally directed treatment.

Communities of color need stable recovery support institutions that can move beyond brief experiments in recovery initiation toward prolonged recovery maintenance. It is this very need that has contributed to the dramatic growth of A.A., N.A., and recovery-focused ministries in communities of color. For those who need sustained professional support, RM provides a culturally viable model of addiction treatment that replaces crisis intervention with a much longer, but lower-intensity, continuum of pre-treatment, in-treatment, and post-treatment recovery support services.

### A Recovery Management Partnership

> *Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work.*
>
> — Albert Schweitzer, From *Reverence for Life*, 1993

The service relationship within acute care approaches to addiction treatment is based on an "expert" model of problem intervention. In this model, the service professional is assumed to have considerable knowledge, resources, and power, while the service recipient is assumed to suffer from one or more problems that he or she does not understand and cannot resolve. The role of the expert is to diagnose the problem, treat the problem, and briefly educate the client regarding his or her continued self-care responsibilities related to the problem. Failure to resolve the problem is usually attributed to the lack of "patient compliance" with the expert's recommendations. The service relationship within the AC model of intervention, whether in the form of an emergency room visit for a broken bone or brief addiction treatment, is hierarchical, transient, and commercialized. It reflects what Eisler (1987) has christened the "dominator model" of interpersonal relationships.

The historical victimization and abandonment of people of color have left a legacy of mistrust and caution when approaching relationships characterized by high discrepancies of power, brevity of contact, and paid helpers. Given this legacy, developing trust in service relationships with people of color requires testing and time, and time is the one commodity the AC model, by definition, cannot provide.

RM models provide an alterative by providing continuity of contact in a sustained service relationship, shifting the nature of that relationship from one based on hierarchy to

one based on a recovery management partnership, and incorporating support relationships that are natural (reciprocal) and non-commercialized. In the RM partnership, it is assumed that strengths and weaknesses exist on both sides of the relationship, and that there is no universally effective professional intervention for severe AOD problems. Where the expert model is based on a teacher-student relationship, the partnership model assumes that learning will be mutual within the service relationship. A number of recovery initiation and maintenance strategies are co-developed and tried within the partnership relationship until the most effective strategy is found. At any point, if previously successful strategies are no longer working, experiments are reinitiated to develop new, more stage-appropriate strategies. This approach rests on the assumption that strategies that work to achieve stability in early recovery may not work in the later stages of recovery. Continuity of contact over time is crucial to the RM model, making the issue of high staff turnover a potential Achilles heel of the RM model.

A second Achilles heel of the RM partnership model is the danger that it could evolve into patterns of prolonged dependency that already exist in the AC model. Cultivating professional dependence and creating "system-sophisticated" clients who know how to "do treatment" and manipulate resources to sustain active addiction is counterproductive and constitutes another form of colonization (using such clients as a cash crop to run the institutional economies of service industries and sustain the careers of service professionals). The goal of RM is a habilitation process that replaces dependency on formal service systems with interdependency within a larger social and cultural community. The essential principle is that professionally directed services are the last, not the first, line of response to AOD problems, and that professionally delivered RM services should provide only what cannot be provided within the larger network of family and indigenous community supports.

Another aspect of the RM service relationship is that the roles of service professionals within this model are multidimensional rather than specialized. In the RM model, the functions of outreach, engagement, assessment, case management, therapy, advocacy, and prevention may all exist over time within the same service role and relationship. This requires a higher level of cross-training than is necessary in the AC model. This broadening of the service role and extension of the duration of the service relationship also forces a rethinking of some of the ethical and relationship boundary guidelines that have governed the delivery of addiction treatment. Such guidelines in the AC model are based on the standards governing professional-client relationships in medicine, psychiatry, psychology, and social work. As they have developed in the modern evolution of addiction counseling, such guidelines have generally prohibited or discouraged disclosure of one's recovery status, emotional self-disclosure, contact with clients in their natural environment, gift giving and receiving with clients, and contact with clients after the period of primary treatment (See White and Popovits, 2002). Such guidelines require rethinking in the transition from AC models to RM models, with the ultimate arbitrator of the level of authority and formality within the RM relationship defined by the cultural context and the comfort level of the individual and family receiving services (See Matsuyoshi, 2001). While RM models retain a clear sense of behaviors in the service relationship that are "never okay," the zone of behaviors that are "sometimes okay and sometimes not okay" is significantly expanded. This requires a higher degree of supervision regarding boundary

appropriateness in different cultural contexts and over the stages of a long-term recovery support relationship.

RM models may also force agencies to fundamentally redefine their institutional identities from one of a service-oriented business to that of a member of multiple communities of recovery — membership that brings its own demands for accountability related to competence, consistency, and sustained access to services. Providing continuity of support and defining oneself in terms of personal and institutional membership in local communities of recovery are much more congruent with the natural patterns of helping within communities of color than are the "expert" or "business" models of delivering acute addiction treatment services.

### Culturally Nuanced Research and Evaluation

> *Indian communities recognize all too well that the research process can be intrusive and the results invidious, divisive, and scandalous.*
>
> — Beauvais & Trimble, 1992

> *…attempts to evaluate service programs must have a dual acceptability; that is, they must be acceptable to the rigors of scientific exploration as well as the African-American ethos and worldview.*
>
> — Butler, 1992

Both the acute model and the recovery management model aspire to be evidence based, but the former is based primarily on short-term scientific studies of the efficacy (what works under ideal conditions) and effectiveness (what works under real conditions) of a single episode of brief intervention (McLellan, 2002). The first change within the RM approach to research and evaluation is to extend the time frame under which judgments of efficacy and effectiveness are rendered (White, Boyle, & Loveland, 2002). Evidence that short-term effects of intervention (e.g., brief periods of sobriety) predict later therapeutic outcomes (e.g. sustained recovery) (see Weisner, et al., 2003) tells only part of the story. Time-related deterioration of effects, delayed positive effects, and delayed iatrogenic (harmful) effects of service interventions can be identified only via longitudinal studies. It is also possible that multiple interventions into chronic disorders may have cumulative or synergistic effects (from particular service combinations and sequences) not identifiable through the evaluation of a single service episode.

Because RM is based on a long-term health management partnership with individuals, families, and communities, it calls for a heightened level of sensitivity to constituency attitudes toward scientific research. In communities of color, researchers encounter two significant issues: 1) the distrust of culturally dominant research and 2) different ways of knowing.

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 char-

acterizing the presence or absence of AOD problems in terms of racially dictated biological vulnerability — from the "firewater" myths of racial vulnerability of Native Americans (Westermeyer, 1974; Leland, 1976) to the myth of racial invulnerability of Asians (O'Hare & Tran, 1998[12]). 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 (See Frank, Augustyn, Knight, et al., 2001). They have been shamed by research designs and interpretations that dramatized the problems within communities of color while ignoring their strengths and resiliencies (Coyhis & White, 2002). Observers from within ethnic communities (Casas, 1992) 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.

Given this history, science, 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 (Hermes, 1998). It will require plotting the long-term pathways of addiction recovery in communities of color. It will require coming to grips with different ways in which communities of color determine what is true and what works in the addiction recovery arena. What is most significant, it will shift ultimate ownership of research from academic and funding institutions to the community being studied.

*Scientific knowledge* assumes that truth can be discovered through professional observation and the rational analysis of findings from controlled experiments. It is predicated upon distance and objectivity (knowledge from outside) and is judged to exist only when it has been documented in writing and subjected to professional peer review. There are two other ways of knowing within communities of color, and these exist more in oral tradition than in written words. The first, *historical/cultural truth*, asks, "What has been our past experience on this issue?" Racial memory is an important source of knowledge in communities of color — a source that seems alien to the highly individualist values and "now" orientation of the dominant American culture. Within communities of color, community elders rather than scientists are the ultimate authorities.

The second way of knowing, *experiential knowledge*, is based on the contemporary experiences of individuals, kinship networks, and fellow community members. This way of knowing tends to be concrete, pragmatic, holistic, and commonsensical (Borkman, 1976). One of the authors (Sanders) once attended a seminar in which a renowned researcher on problem gambling declared based on his research that Blacks and Latinos did not have significant problems with gambling. This conclusion did not match his historical/cultural truth as an African American, or the experiential knowledge drawn from his extended

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[12] The so-called "Asian flushing response" to alcohol among some Asians does not constitute a universal protective factor against alcoholism and alcohol-related problems in Asians. There is growing evidence that cultural, not biological, factors shape the prevalence and patterns of alcohol problems across highly diverse Asian populations.

family and neighborhood (within which underground and state-sponsored lotteries were a prominent feature). When Sanders asked about the nature of the expert's research, he learned that it was based on a membership survey of Gamblers Anonymous conducted at predominately suburban meeting sites. When Sanders did his own research using focus groups with African Americans and Latinos in urban areas, he discovered clear patterns of problem gambling within these communities.

Word-of-mouth knowledge, captured in the collective stories of a community or a people, constitutes a key source of truth in communities of color. Communities of color do not reject science as much as require that its findings be filtered through the sieve of personal and community experience. In contrast to scientific knowledge, this way of knowing assumes that truth can be discovered only through proximity and experience (knowledge from inside). The authors have witnessed mainstream scientists speaking at "town meetings" in African American communities. When these scientists decry the lack of evidence on the effectiveness of indigenous frameworks of recovery (e.g., faith-based and other cultural mediums of recovery), they are somewhat flummoxed to see members of the audience stand to declare that they or their family members are the "living proof" of such effectiveness. David Whiters of Recovery Consultants of Atlanta, Inc. notes, "I have watched many among the African American community begin their recovery in traditional recovery programs, only to find sustained recovery in the Black Church" (Personal Communication, December, 2003). Such long-term observations over spans of time that far exceed the follow-up periods in most research studies constitute their own form of collective truth. Living stories (experiential authority) have more power and cultural credibility than statistics (professional/scientific authority) within many communities of color. Living stories are best viewed as a unique and legitimate type of evidence rather than "myths" or "folklore" (Hermes, 1998). This does not mean that the usual methods of scientific analysis are abandoned, but that voices of the community are allowed to reach directly those who hear and read about the community through the medium of scientific research.

RM models will be required to pass the litmus test of multiple ways of knowing if they are to achieve credibility within and outside communities of color. The development of evidence-based services is a fundamental tenet of RM, but in communities of color the nature of that evidence will have to be broadened via qualitative studies that capture the historical and contemporary experience within communities of color. RM models in communities of color will also have to shift from an exclusively academic to a more activist orientation (studying questions of importance to the community, focusing on knowledge that can facilitate positive personal, family, and community change), enter into a research partnership with the community (e.g., control over design, conduct, interpretation, and dissemination), and respect the community's ownership of its own knowledge. We also anticipate that research in communities of color will shift from summative evaluation (measuring the effects of an intervention only after it is concluded) to formative evaluation (measuring and communicating the effects of an intervention at multiple points during and after its delivery, so that it can be refined and improved).

## A Recovery Management Agenda

This paper has contrasted acute care (AC) and recovery management (RM) models of in-

tervention into serious AOD problems. It is suggested that RM models offer advantages to communities of color in eight specific areas:

- an ecological perspective on the etiology of AOD problems;
- a broadened target of intervention (including families, kinship networks, and communities);
- a proactive, hope-based model of service engagement;
- the inclusion of indigenous healers and institutions;
- an expanded menu of culturally grounded recovery support services and catalytic metaphors;
- an extended time-frame of recovery support;
- a partnership-based service relationship; and
- a culturally nuanced approach to research and evaluation.

The reader may ask, "Where are these models of recovery management?" The answer is that there may not be any treatment organizations that have fully developed all of the elements of RM described in this paper. RM exists as an emerging model whose service elements are currently being piloted and evaluated. The RM model exists within progressive treatment programs that are experimenting with new approaches to pre-treatment engagement and post-treatment continuing care. The model exists within the growing number of experiments with peer-based recovery support services. It exists within the growing network of peer-managed recovery homes in the United States. And, perhaps most significantly, its potential is demonstrated in the growing number of recovery-focused religious and cultural revitalization movements within American communities of color. That potential exists in a vibrant Wellbriety Movement in Indian Country. It exists within Glide Memorial Church, where a majority of parishioners are in recovery. It exists in the Nation of Islam's outreach to addicted African Americans in prison. It exists in the hundreds of thousands of people of color who each day use Twelve-Step programs and other recovery mutual aid societies to quietly achieve another day of sobriety and wellness. The challenge is to build connecting tissue between treatment and recovery by building bridges between these indigenous recovery movements and addiction treatment institutions.

RM holds great promise in communities of color, but fulfillment of that promise hinges on:

1. involving clients, families, and service professionals from within communities of color in a process of shifting existing interventions from AC models to locally designed, operated, and evaluated RM models;
2. developing recovery management teams and advocacy coalitions via the integration of AOD service providers and indigenous institutions;

3. confronting forces in the community that promote excessive AOD use;

4. enhancing "community recovery capital" (Granfield & Cloud, 1999);

5. increasing the presence and visibility of indigenous sobriety-based support structures;

6. providing recovery education within communities of color; and

7. using recovery role models that illustrate the viability and variety of recovery pathways within communities of color.

Achieving that vision will require that the field of addiction treatment fundamentally redefine the sources of and solutions to AOD problems and, in the process, redefine itself.

The authors conclude this paper as we started it, not as authorities, but as students. Any errors of perception or omission in these pages stand as testimony that this learning is, and will forever remain, incomplete. We submit this paper as a work-in-progress to the communities that helped spawn it and welcome continued guidance as we continue the task of making this alternative vision a reality in communities across America.

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## About the Great Lakes Addiction Technology Transfer Center

The Great Lakes Addiction Technology Transfer Center (ATTC) is part of a national network that includes 14 regional ATTC's and a National Office. Funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT), the ATTCs have been charged with the mission of unifying science, services, and education to transform lives. Established in 1998, the Great Lakes ATTC is part of the Jane Addams College of Social Work, University of Illinois at Chicago. The Great Lakes ATTC uses educational products, training, technical assistance, information dissemination, collaboration, systems-change initiatives, and other technology transfer interventions to help prepare the addiction treatment field and allied health fields for the most effective evidence-based practice. The Great Lakes region includes Illinois, Indiana, Michigan, Ohio, and Wisconsin.

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## Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity

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### Abstract

*The recent growth in peer-based recovery support services as an adjunct and alternative to addiction treatment has created heightened ambiguity about the demarcation of responsibilities across three roles: 1) voluntary service roles with communities of recovery, e.g., the role of the sponsor within Twelve Step programs, 2) clinically-focused addiction treatment specialists (e.g., certified addiction counselors, psychiatrists, psychologists and social workers), and 3) paid and volunteer recovery support specialists (e.g., recovery coaches, personal recovery assistants) working within addiction treatment institutions or free-standing recovery advocacy/support organizations. The purpose of this paper is to enhance understanding of these new recovery support roles by comparing and contrasting these three service roles.*

### Introduction

New service roles sprout from the soil of unmet need. In the current worlds of addiction treatment and addiction recovery, a new role is emerging to bridge the chasm between brief professional treatment in an institution setting and sustainable recovery within each client's natural environment. This role is embraced under numerous titles: recovery coach, recovery manager, recovery mentor, recovery support specialist, recovery guide, personal recovery assistant, and helping healer. This role has been described in an earlier essay on peer-based recovery support services (White, 2004b) and will be referred to generically as *recovery coach* in this essay.[1]

[1] For additional descriptions of this role see http://www.dawnfarm.org/articles/recoverycoach.pdf. and www.bhrm.org/guidelines/Recovery%20Coach%20and%20Recovery%20Planning%20Manual.doc

The growing popularity of the recovery coach (RC) role is evident in both public and private mental health and addiction treatment organizations.[2] Peer-based service models are growing rapidly in the mental health service arena, particularly for clients with co-occurring psychiatric and substance use disorders (Mowbray, Moxley, Jasper & Howell, 1997; Davidson, Harding & Spaniol, 2005). There is a growing body of mental health evaluation data on the benefits of peer-based recovery support services for consumers, those who provide these services, and to the mental health service delivery system (for reviews, see Solomon, 2004; Solomon & Draine, 2001; Christensen & Jacobsen, 1994).

The modern era of addiction treatment (dating from its key enabling legislation in 1970)[3] drew from its own earlier history as well as concurrent reports on the potential effectiveness of peer-facilitated models of change in other human service arenas (Riessman, 1965; Durlak, 1979; Hattie, Sharpley & Rogers, 1984; Riessman, 1990) to posit the recovering "paraprofessional" counselor as the central role within an expanding network of community-based addiction treatment programs (Connett, 1980; Galanter, Castaneda & Salamon, 1987; Blum & Roman, 1985). The original focus of this role—personal guidance into and through the recovery process and nesting each client within a larger community of individuals and families in recovery—was diminished in the subsequent professionalization of the addiction counselor but has been resurrected in the role of the recovery coach.

Evidence of this shift toward sustained peer-based recovery support services is evident in many quarters.

- The primary focus of the Center for Substance Abuse Treatment's Recovery Community Support Program shifted in 2002 to the development of peer-based recovery support services.
- A number of states (e.g., AZ, CT, PA) are funding new peer-based recovery support projects and establishing credentialing systems that set standards for serving in this role (e.g., GA).
- Efforts to transform urban behavioral health services into recovery-oriented systems of care, such as what is occurring in the City of Philadelphia, are including an emphasis on peer-based recovery support services.
- Major accreditation bodies, such as the Joint Commission on Accreditation of Health Care Facilities, are issuing standards for peer-based recovery support services.

There are several key research findings that underscore the need for sustained recovery support services and the potential of the recovery coach role. A growing number of studies confirm that addiction recovery:

- begins prior to the cessation of drug use;
- is marked in its earliest stages by extreme ambivalence;
- is influenced by age-, gender-, and culture-mediated change processes;
- involves predictable stages, processes, and levels of change; and that
- those factors that maintain recovery are different than the factors that initiate recovery (Waldorf, 1983; Frykholm, 1985; Biernacki, 1986; Grella & Joshi, 1997; Wechsberg, Craddock & Hubbard, 1998; Klingemann, 1991; DiClemente,

[2] See http://www.cocaine-addiction.co.uk/recovery_coaching.htm , http://www.fairbankscd.org/Coaches.htm and http://www.hiredpower.com/.

[3] The Comprehensive Alcoholism Prevention and Treatment Act of 1970 (Hughes Act) and the Drug Abuse Treatment Act of 1972.

Carbonari & Velasquez, 1992; Prochaska, DiClimente & Norcross, 1992; Humphreys, et al, 1995).

These findings suggest that the types of needed clinical and non-clinical recovery support services differ across clinical populations and differ within the same individual across the developmental stages of his or her addiction and recovery careers.

The importance of early and sustained recovery support is further indicated by treatment-related studies confirming that:

- most people with alcohol- and other drug-related problems do not seek help through mutual aid or professional treatment (Kessler, 1994; Cunningham, 1999; Cunningham & Breslin, 2004),
- less than half of those admitted to publicly funded addiction treatment successfully complete treatment (SAMHSA, 2002; Stark, 1992),
- more than 50% of individuals discharged from addiction treatment resume alcohol and/or other drug (AOD) use within the following twelve months (Wilbourne & Miller, 2003), most within 30-90 days of discharge (Hubbard, Flynn, Craddock & Fletcher, 2001),
- recoveries from severe AOD problems are not fully stabilized (point at which the risk of future lifetime relapse drops below 15%) until between four to five years of sustained remission (Vaillant, 1996; Dawson, 1996; Jin, Rourke, Patterson, et al, 1998) or longer for some patterns (e.g., opiate addiction) (Hser, Hoffman, Grella, & Anglin, 2001),
- the transition from recovery initiation to lifelong recovery maintenance is mediated by processes of social support (Jason, Davis, Ferrari & Bishop, 2001; Humphreys, Mankowski, Moos & Finney, 1999), and
- assertive approaches to post-treatment continuing care can elevate long-term recovery outcomes in adolescents (Godley, Godley, Dennis, et al, 2002) and adults (Dennis, Scott & Funk, 2003).

People with severe AOD problems are often so deeply enmeshed in a culture of addiction that they require sustained help disengaging from this culture and entering an alternative culture of recovery (White, 1996). All of the above studies buttress the growing call for sustained pre-treatment, in-treatment, and post-treatment recovery support services (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle & Loveland, 2002). The role of recovery coach may well become the central mechanism through which such services are delivered.

Considerable effort is underway to answer key questions related to the recovery coaching functions (e.g., should these functions be integrated into an existing role or within a new service role?) and to determine where these functions can be best placed organizationally (e.g., are recovery support services best integrated within existing addiction treatment programs or within free-standing, peer-based recovery advocacy and support organizations?).[4] The piloting of the recovery coach role around the country is triggering such questions and comments as: 1) "Why do people need a recovery coach if they have access to a Twelve Step sponsor?" and 2) "We don't need recovery coaches. These functions are already being performed by addiction counselors, outreach workers and case managers."

If it is to survive, a new service role must stake out its distinctive turf and justify its

[4] Debate of this question will intensify, with many recovery advocates taking the position that the functions of professional treatment and non-clinical recovery support services need to be organizationally segregated to maintain their true peer status, while others will argue that clinical treatment and non-clinical recovery support services are best integrated within a single organizational framework. There are no studies at this point on the relationships between these respective frameworks and recovery outcomes.

existence, and it must do so in the context of other roles claiming the same or adjoining territory. The recovery coach role incorporates and refines some dimensions of existing roles (e.g., outreach worker, case manager) and is positioned between two other recovery support roles: the recovery support group sponsor[5] and the addiction counselor. The purpose of this essay is to differentiate the recovery coach, sponsor, and addiction counselor roles and to discuss the importance of clearly defining and maintaining the boundaries of these roles. We will begin with a brief history of the evolution of voluntary and paid service roles that have guided people into and through the process of recovery from severe alcohol and other drug (AOD) problems.

## The Evolution of Specialized Recovery Support and Service Roles: A Brief History[6]

The ancient art of Thebes and Egypt portrays the slaves of those addicted to alcohol caring for their masters by administering medicines and other physical treatments (Crothers, 1893). People specializing in helping those recovering from the acute and chronic effects of addiction are as old as humankind, but there is a distinctive history of these roles in the United States dating from the eighteenth century. As alcohol problems rose among Native American tribes and within colonial communities, abstinence-based social and personal reform movements rose up that contained the first specialized roles whose purpose was to ignite and sustain the recovery process. These earliest American recovery movements involved the first recovery mutual aid societies and America's first addiction treatment institutions (inebriate homes, inebriate asylums, addiction cure institutes, religious missions, and inebriate colonies).

The Washingtonian revival of the 1840s enticed more than 400,000 alcoholics to sign a temperance pledge and participate in regular "experience sharing" meetings for those who had pledged to remain sober. The new role of the reformed temperance leader challenged the authority of physicians and clergy who had served as the early leaders of the American temperance movement. Reformed men like John Gough and John Hawkins traveled from community to community giving charismatic speeches, offering personal consultations to alcoholics and their family members, and helping establish local recovery support groups. The financial payment these early recovery missionaries received from donations at their speeches or from the salaries they were paid by temperance organizations became a point of considerable controversy as mainstream members of these early recovery societies accused these leaders of profiteering. The Washingtonian societies collapsed within a decade and were replaced by fraternal temperance societies and ribbon reform clubs. Many of these groups lost their vitality over time via restrictive membership criteria (limiting membership "only to drunkards of good repute") and by loss of their outreach and community service functions.

Competing with these early recovery support groups for ownership of AOD problems were two other groups: the physicians who headed the newly formed inebriate asylums and addiction cure institutes and the lay religious figures who were organizing urban missions and rural inebriate colonies. Mainstream physicians and clergy looked with suspicion or outright disdain at the growing numbers of reformed persons who were beginning to organize their own institutions for the care of the addicted. Controversies over recovering people serving as paid helpers raged both within recovery mutual aid societies and within professional treatment organizations.

Dr. T. D. Crothers, Editor of the *Journal of Inebriety,* wrote an 1897 editorial attacking the idea that personal experience of addiction was a credential for understanding and treating addiction. He claimed that those who cared for inebriates following their own cures were incompetent by reason of organic defects of the higher mentality, and caring for inebriates heightened the recovering person's vulnerability for relapse. Most of this debate over the source

[5] The term sponsor here will refer to both this specific role within Twelve Step recovery programs as well as the counterpart to this role in other recovery support frameworks.

[6] This history is drawn from White, 1998 and White, 2001.

of special expertise to help persons wounded by alcoholism and other addictions was lost in the larger collapse of addiction treatment institutions in the opening decades of the twentieth century.

From the ashes of this collapse rose an effort in 1906 by the Emmanuel Church in Boston to integrate religion, psychology, and medicine in the treatment of mental disorders. Quickly developing a specialty in the treatment of alcoholism, the Emmanuel Clinics pioneered the use of lay alcoholism psychotherapists, a sober social club (the Jacoby Club), and the use of "friendly visitors" (established recovering members making home visits with newer members). Lay therapists such as Courtenay Baylor, Francis Chambers, and Richard Peabody became quite well known through their clinical practices and their writings, but lay therapists were routinely threatened with lawsuits for providing medicine without a license.

The founding of Alcoholics Anonymous (AA) in 1935 led to the emergence of several new service roles in the 1940s. The AA sponsor role and the core of today's sponsorship rituals emerged from the explosive growth of AA in Cleveland following a series of local newspaper articles on AA published in1939[7]; AA physicians and nurses worked with new "AA Wards" in hospitals in Akron, New York and Philadelphia; AA members offering peer support to others with alcohol problems led to paid positions as the first industrial alcoholism specialists in the 1940s (the pre-cursor to today's employee assistance programs); and AA entrepreneurs began opening "AA Farms" and "AA Retreats".

The tension between peer support and professional care was played out repeatedly in this early history in response to such events as AA co-founder Bill Wilson's offer to work as a lay therapist at Charles Towns Hospital in New York City. There were impassioned debates over the distinction between and relative importance of psychological treatment on the one hand and AA spirituality and fellowship on the other.[8] The result was a delineation of guidelines (particularly AA's Twelve Traditions) governing how AA members should and should not perform certain roles within a re-emerging alcoholism treatment industry. Other Twelve-Step programs and alternative recovery support groups utilized or emulated these AA guidelines. Such guidelines did not completely eliminate the personal and professional double bind that recovering people experienced working in the treatment field.

There were several threads in the emergence of the modern addiction counselor role. There was the continuation of the lay therapist tradition with such model programs as the clinics operated by the Yale Center for Studies in Alcohol in the 1940s and 1950s. There was the codification of the "counselor on alcoholism" role within the "Minnesota Model" of alcoholism treatment pioneered at Pioneer House, Hazelden, and Willmar State Hospital. There was the "community alcoholism consultant" role of those working within the 1960s anti-poverty programs and within some state programs (a role that focused more on community resource development than clinical assessment and treatment). There were those ill-defined roles of those working within the rising halfway house movement of the 1950s and 1960s. And there were the "ex-addict counselors" working within the growing network of therapeutic communities and methadone maintenance programs. As funding first increased for treatment services in the 1960s, a lively debate ensued over the question of whether formal education or recovery experience qualified one to treat the alcoholic and addict (see Krystal & Moore, 1963). While this debate was going on in professional circles, recovery support societies raised concerns that

[7] The original AA sponsorship pamphlet written by Clarence S. in 1944 defined the key aspects of sponsorship as it emerged: 1) qualify yourself as an alcoholic; 2) tell your story; 3) inspire confidence in AA; 4) talk about "plus" values (happiness, peace of mind, material benefits); 4) show importance of reading the Big Book; 5) explain qualities required for success in AA; 6) introduce faith; 7) listen to the prospect's story; 8) introduce the prospect to several meetings; 9) explain AA to prospect's family; and 10) prepare the prospect for the hospital experience.

[8] See Marty Mann's eloquent distinction quoted in White, 1998, p. 174.

the quantity and quality of their own service work was weakening in tandem with the growth of the professional treatment industry.[9]

The "paraprofessional" roles of "alcoholism counselor" and "drug abuse counselor" of the 1970s, birthed within the earlier lay therapy tradition, were rapidly professionalized and modeled on the roles of psychiatrist, psychologist and psychiatric social worker. Education and training requirements rapidly escalated in tandem with certification and licensing systems as addiction counselors defined themselves as a "new profession." Personal recovery became de-emphasized, and many programs prohibited recovering counselors from sharing that status with their clients. The same was true for recovering people serving other professional roles in the treatment field, e.g., physicians, nurses, psychologists, and social workers. As the percentage of treatment professionals in recovery declined, recovering people continued to work in other non-clinical service roles within the treatment field, e.g., outreach worker, case manager, house manager, residential aide, detox tech, research assistant (trackers, interviews and case managers), and follow-up worker.

The emergence of the recovery coach role in the past decade has emerged from the recognition of the need to reconnect addiction treatment to the more enduring process of addiction recovery, to effectively link clients from treatment institutions to indigenous communities of recovery, and to address complex co-occurring problems that inhibit successful recovery. These recognitions are part of a larger shift in the design of addiction treatment from a focus on acute biopsychosocial stabilization to a focus on sustained recovery management. 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), and
- a friend (provides companionship).

Equally important, the RC is NOT a:

- sponsor (does not perform AA/NA service work on "paid time"),
- therapist (does not diagnose, probe undisclosed "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

[9] Concerns about the erosion of service and the "downgrading of sponsorship" were expressed in the *AA Grapevine* beginning in the late 1960s; see Sponsorship: Source of Wisdom, May, 1967.

- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church) (Excerpted from White, 2004b).

The words most frequently used to describe what the RC does include the following: identify, engage, encourage, motivate, share, express, enhance, orient, help, identify, link, consult, monitor, transport, praise, enlist, support, organize, and advocate. The fact that the RC fulfills all of these functions is a strength and vulnerability of the RC role.

## The Lessons of History

There are a number of observations and lessons that could be drawn from this brief history that are relevant to our continued exploration of the recovery coach role. Recovery and Community: Professionalizing recovery support can inadvertently undermine the quantity and quality of natural support for recovery that exists within families and social networks, peer-based recovery support groups, and the larger community (McKnight, 1995). When diminished or lost, this service commitment can be rekindled through internal renewal processes. Such a renewal process is occurring within many AA and NA groups who are re-dedicating themselves to carrying a message of hope to those who are still suffering. Great care must be taken in the emergence of new structures and roles not to undermine the natural recovery capital[10] that exists within local communities. The goal of such structures and roles should be to elevate and supplement natural recovery support, not replace it.

Community Connection and Disconnection: Recovery support roles that emerge with very close connections to communities of recovery are prone to disconnect from those communities over time as the persons filling those roles come to see the primary source of their power and authority coming from within themselves and from their professional organizations. Staying connected to communities of recovery and the larger communities in which they are nested is critical to the sustained integrity of recovery support roles.

Problem Source and Solution: Approaches to the resolution of AOD problems vacillate between clinical models that place the sources and solutions to AOD problems within the individual and models that view the sources and solutions to AOD problems rooted in the relationship between the individual, family and community. The former focuses on clinical diagnosis and treatment of the individual; the latter focuses on development of individual, family, and community recovery capital and emphasizes strategies of cultural renewal and community development. The recovery coach role bridges these dichotomized views via its emphasis on reconnection to community as an important healing force (For broader recognition of the healing power of community, see Jason & Kobayashi, 1995 and White, 2002).

Ambiguity and Conflict: There is a long history of role competition and conflict between human service generalists and addiction specialists and between particular specialty roles within the addictions field. These conflicts are rooted in different conceptions of the sources and solutions to AOD problems and the question of whether those helping people with severe AOD problems should be credentialed by experience or by formal education. They are also rooted in efforts to protect the legitimacy of particular roles and the personal/institutional financial interests imbedded within them.

Essence of Recovery Support Relationship: Helping roles in the addictions field are historically distinguished from helping roles in other health and human service fields by:

- theoretical foundations (e.g., belief that severe and persistent AOD problems constitute a primary disorder rather than a superficial manifestation of other problems),

[10] Recovery capital is a term introduced by Granfield and Cloud (1999) to describe the internal and external assets required for successful recovery initiation and recovery maintenance.

- emphasis on the use of self in the helping process via belief in the power of "wounded healers"—the recognition that experiencing and overcoming an affliction can engender knowledge that can be used to help others similarly afflicted,
- service relationships built on a foundation of moral equality and emotional authenticity, and
- belief in the healing powers of connection to communities of recovery whose members are bound by their experience, strength and hope (White, 2004a).

Profiteering: Recovery movements can be used as a platform for personal and institutional profiteering. This happens when resources that should flow into the community to support recovery initiation and maintenance are diverted to support service organizations and their leaders. This potential can be checked by elevating stewardship of community resources as a core organizational value and by holding the organization and its service workers accountable to local communities of recovery.

Personal Vulnerability/Exploitation: Historically, those filling recovery support roles are vulnerable for exploitation and work-related distress. Recovery support specialists have at times been ill chosen and provided inadequate orientation, training and supervision. Recovery support specialists have also found themselves marginalized and isolated—cut off from the sources of natural support for their own recoveries, while not being fully accepted by other members of the interdisciplinary teams to which they were loosely connected. The resulting role ambiguity, role conflict, and inadequate role support has sometimes set the stage for the recovery specialist's own relapse (White, 1979; Wilson, 1984). Adding to this vulnerability is a history of recovering people being financially exploited by treatment institutions via excessive work schedules, inadequate compensation and benefits, the highest risk work assignments, and a lack of support for career development.

Service Relationship Transformation: There is a tendency via processes of professionalization to move recovery support relationships that are natural, reciprocal, enduring, and non-commercialized to relationships that are hierarchical, transient, commodified, and highly commercialized. These relationships may also move from a voluntary to a coerced status under the influence of external control agents such as the criminal justice and child protection systems. When role occupation occurs, new service roles rise that emulate the lost qualities of the former service relationship. The industrialization and professionalization of a service field also tends to shift the focus of the field and the service roles from the needs of those being served to the needs of the institution and the profession. Ironically, the recovery coach role re-elevates many of the functions and relationship dimensions of the early alcoholism counselor that were lost on the road to professionalization. There is also a tendency within recovery mutual aid societies to experience a weakening of their governing service ethic over time. When this occurs, new mutual aid structures and service roles emerge to recapture that lost focus.

Service Ethics: Those served by non-clinical recovery support roles are vulnerable to both exploitation and injury from well-intended but poorly chosen or poorly executed service interventions. The potential for exploitation and injury rises in tandem with the discrepancy of power between the service provider and service consumer. There is a need for standards of ethics and etiquette governing non-clinical recovery support services. The purposes of such standards are to protect service consumers, service providers and their families, service organizations, the service field, and the community.

Role Viability: The fates of recovery support roles are closely tied to the fates of the larger movements of which they are a part. The social stigma attached to addiction and the probationary status of addiction treatment as a cultural institution have contributed to earlier collapses of the field, weak organizational infrastructures, role instability and a transience of the service workforce. The fate of recovery support roles and institutions is contingent upon advocacy efforts that challenge stigma and reaffirm cultural beliefs about the potential for

recovery from severe AOD problems. The recovery coach role is sustainable only in communities committed to creating and maintaining the physical, psychological, and social space where recovery can occur.

## A Service and Support Continuum

It is time to step back from this brief history of recovery support roles to look at the broader picture of the resources that can be drawn upon to support addiction recovery. These resources constitute an ecological onion. At the center circles of this onion are resources within the self and resources within each individual's family and social network. That intimate network is in turn embraced by resources from the immediate environment--neighborhoods, schools, churches, workplaces, health clinics. Here, one can find sources of lay and professional advice as well as formal recovery mutual aid societies and the special support relationships that exist within them, e.g., sponsors. Beyond this second ring lies the volunteer and paid recovery support specialists who are the service tentacles of addiction treatment agencies, and the physicians, nurses, and counselors who deliver the clinical services at those agencies. These organizations are often connected to a large world of non-specialty health and human services filled with physicians, psychiatrists, psychologists, and social workers as well as such social control agents as judges, probation officers, child welfare workers, and professional licensing boards.

As AOD problems become increasingly enmeshed in other problems, individuals with these problems interact with roles at all levels of this service ecosystem. In fact, those with the most severe, chronic, and complex problems interact repeatedly with these resources, often without measurable effects on the trajectory of their problems. The problem is how we move from these isolated roles and fragmented service systems to an integrated circle of recovery support. One of the functions of the recovery coach (similar to the role played by case managers in the last 20 years) is to provide the connecting tissue that can turn a categorically segregated service system into a more holistic system of care by linking multiple episodes of care, integrating the resources of multiple formal and informal resources, and supporting individuals and families in recovery over time.

There are several broad principles of collaboration that can help guide the relationships between lay, volunteer, and professional helpers.

1. Lay and professional helpers should not do anything for the individual or family members over time that they are capable of doing for themselves.
2. Professional agencies and roles should not provide services to the community in response to needs that can be met within the client's natural support system.
3. Professional helpers should avoid creating barriers to client contact with local communities of recovery, e.g., scheduling service activities at times that conflict with community recovery meetings, restrictive visitation policies that prevent contact while individuals are in residential treatment modalities.
4. Persons occupying all roles should accurately represent their education, training and experience as well as the basis upon which their recommendations are being made.
5. Conflicts between those filling these roles are best resolved within a framework of mutual respect.
6. All recovery support roles share a commitment to help those they serve and to not exploit this relationship for personal or institutional gain. All parties have a responsibility to immediately confront such exploitation if it occurs.

The question is not, "Which of these roles is THE most important in the recovery process?" Each contributes different ingredients to the recovery process at different stages of individual and family recovery. The question is, "How can such resources be bundled and

sequenced in ways that widen the doorway of entry into recovery and enhance the quality of recovery?" Achieving that vision requires the availability of multiple support roles that are accessible at key points within one's addiction and recovery careers as well as the careful delineation of the boundaries of these roles.

One of the sources of role ambiguity and conflict between sponsors and recovery coaches is the commonalities that are shared by these roles. Persons filling both roles:

- are credentialed by experience rather than formal education and training[11],
- establish non-hierarchical (or minimal-hierarchy) relationships based on a mutuality of shared experience,
- rely on self-disclosure and advice,
- focus on removing obstacles of recovery and building recovery capital
- model core recovery competencies[12], and
- maintain continuity of contact over time with those needing recovery guidance and support.

In spite of such commonalities, there are distinct differences in the roles of Twelve Step sponsor and recovery coach.

## How Recovery Coaching Differs from Sponsorship

It is something of a challenge to compare the roles of recovery coach (RC) and sponsor. The former is now emerging in different forms across the country and has yet to be codified; the latter, while existing for more than 60 years, has been governed more by oral tradition than written procedures.[13] There are numerous ways the role of RC is being defined and performed, many different styles of Twelve Step sponsorship[14] within local Twelve Step groups, and many variations in the counterpart to the sponsor role in religious and secular recovery support groups. The following observations are drawn from the author's study of the history of sponsorship and from observations of the RC role across the country. Seen as a whole, the RC role, as it is emerging in the United States in the opening decade of the twenty-first century, differs from the role of Twelve Step sponsor and its counterparts in a number of distinct and important ways.

Organizational Context: Where the sponsor serves as a representative of a voluntary, financially self-supported recovery mutual aid society, the RC works as a representative of a formal service organization bound by accreditation, licensing, and funding guidelines that shape accountabilities within the RC role that are not present in the sponsor-sponsee relationship. Those different accountabilities are reflected, in part, in service documentation responsibilities that can range from minimal to excessive for the RC and which do not exist for the sponsor.

Service Context: Where the sponsor-sponsee relationship occurs in relative isolation from professional helpers, the RC service relationship often occurs within the context of a multidisciplinary service team and a formal treatment plan or recovery plan. Many decisions that are the sole purview of the sponsor (e.g., the number of individuals to work with at one time, the physical settings in which service activities occur, when to terminate the service relationship) are dictated to the RC by the organization for which he or she works. There are professional peer

[11] Recovery coaches, sponsors and those they serve are all members of an "exclusive club"—"exclusive because each one has paid the highest entrance fee that can be paid." (A Sponsor is…, A.A. Grapevine, January, 1970, p. 29.)

[12] Such competencies include modeling of core recovery values (e.g., tolerance, acceptance, gratitude), the capacity for self-observation, self-expression, sober problem-solving; recovery-based reconstruction of personal identity and interpersonal relationships; freedom from coercive institutions; economic self-sufficiency; positive citizenship and public service.

[13] There is AA conference-approved literature on sponsorship (See Questions and Answers on Sponsorship pamphlet) and popular books on Twelve Step sponsorship (see Hamilton B., 1996).

[14] See A.A. Grapevine, Sponsorship Relationships, September, 1975.

accountabilities and collaboration skills required in the RC role that are not present in the sponsor role.

Philosophical Framework: Where the sponsor provides support **within** a particular program of recovery, the RC provides recovery support **across** multiple religious, spiritual, and secular frameworks of recovery.[15] The sponsor emphasizes the viability and superiority of the Twelve Step program as a framework for successful recovery ("It works if you work it"); the RC emphasizes a philosophy of choice that recognizes the legitimacy of multiple pathways of long-term recovery. The operational motto of the best RCs 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 and Kurtz, 2005). The focus is on the goal, not the method.

The practical implications of this orientation are that the RC:

- conveys the legitimacy of multiple pathways to those with whom he or she serves,
- understands the language, catalytic metaphors[16], and rituals reflected within these pathways,
- works to expand the variety of recovery support structures within the communities he or she serves, and
- develops collaborative relationships with the individuals and groups representing these pathways.

Scope of Those Served: Where the sponsor's services are limited to those who have "a desire to stop drinking" and to those who have sought help within a local recovery support program, the RC serves a larger group of people, including those who may not yet have a desire to stop drinking and those who are seeking recovery but are opposed to participation in a particular recovery program. As a representative of a particular recovery program, the sponsor begins from the position of "If you want what we have…". In contrast, the RC works with individuals who are not yet at that point or who may want it but continue to relapse. Where sponsors may terminate sponsorship of those who continue to relapse, the recovery coach continues to provide *recovery priming* under such circumstances. The RC engages clients prior to recovery initiation and prior to first contacts with mutual aid groups, continues those contacts even in the face of relapse, and sustains contact (via recovery check-ups) after some clients will have disengaged from active participation in mutual aid groups. In general, the RC role is much more assertive than the role of sponsor in engaging individuals whose character traits (including self-defeating styles of interacting with lay and professional helpers), problem complexities, and environmental obstacles to recovery pose significant challenges to recovery initiation.

Degree of Reciprocity and Power in the Service Relationship: Where the sponsor-sponsee relationship is based on a reciprocity of need (the sponsor is there in part to support his or her own sobriety)[17], the recovery coach has a fiduciary relationship with those he or she serves—a relationship governed by ethical/legal duties and obligations. Where there is minimal power differential in the sponsor-sponsee relationship (there are definite exceptions to this[18]), there is at least moderate power differential in the recovery coach service relationship. The long-term sponsorship relationship often evolves into an enduring friendship and a form of mutual

[15] I am aware that some RCs emphasize only one pathway of recovery (e.g., Twelve Steps, Christian conversion), but such singularity of focus is the exception in my visits with RCs across the country.

[16] 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.

[17] AA is very clear on this point: "In A.A., sponsor and sponsored meet as equals…." (AAWS, Inc., 1983, p. 7).

[18] The potential for such power differential is reflected in references in *AA Grapevine* articles about possessive and controlling sponsorship styles (see My Sponsor, My Friend August, 1982; A Sponsor Can't be My Higher Power, May, 1972), and in references to the potential for exploitation in texts on sponsorship (see Hamilton B., 1996).

sponsorship (AAWS, Inc, 1983, p. 25), but such sustained reciprocity is less appropriate in the RC service relationship. The vulnerability of persons served within the RC relationship is protected through the use of safeguards that are not present in the sponsor-sponsee relationship (e.g., informed consent, legally governed confidentiality, professional supervision, complaint and redress procedures). At an organizational level, agencies delivering recovery support services via a volunteer model have fiduciary responsibilities to carefully screen, orient, train and supervise RC candidates, as well as discipline or discharge RC volunteers who are not able to competently and ethically deliver services.

Service Menu: Where the primary focus of the sponsor is on the use of Twelve Step Tools (personal story sharing, meetings, step work, literature, sober social activities), the RC works within a formal service continua and is specifically trained to access a broader range of recovery-supportive services (education, employment, health care, housing, day care, transportation, counseling for co-occurring problems, etc.). AA is very clear on the singularity of purpose of the sponsor: "A sponsor is simply a sober alcoholic who helps the newcomer solve one problem: *how to stay sober*" (AAWS, Inc., 1983, p. 10).

Financial Remuneration: Where accepting money for sponsorship or other Twelve Step service work would be a violation of AA's Eighth Tradition[19], recovery coaching may be provided on either a volunteer or paid basis.

Ethical Guidelines and Supervision: Where the primary sources of guidance on sponsorship rest with historical and contemporary practice as expressed through literature on sponsorship and God as expressed in a group conscience, most recovery coaches are held accountable via formal organizational codes of ethics governing their service relationships and through professional supervision of their service relationships and activities.[20] Mutual confidentiality may be negotiated in the sponsor-sponsee relationship, but there are no legal protections related to such disclosures. In contrast, there are ethical and legal requirements for RC confidentiality and punishments (including jail) for breaches of confidentiality. These ethical codes and supervision processes are designed to protect multiple parties: those receiving recovery coaching, those serving as recovery coaches, the service organization, the professional field, and the community. It is very important that persons in dual relationships (e.g., a recovery coach and fellow recovery mutual aid members) scrupulously maintain the separation of these roles. This would mean, for example, that information heard in the context of a recovery support group meeting could not be shared back to the treatment agency within which one works, nor could information acquired in the treatment setting be shared outside of that setting (e.g., to a sponsor) without the client's written permission.

Anonymity: Where personal anonymity is usually maintained in the sponsor's interactions with outside agencies and the press that could potentially occur as part of his or her sponsorship activities[21], the RC has no such anonymity as a formal representative of the agency for whom he or she volunteers or works. RCs may self-identify themselves as persons in recovery, but generally refrain from identifying themselves with a particular program of recovery at the level of press.

Policy Advocacy: Where policy advocacy in one's role as a Twelve Step sponsor is prohibited by Tradition Ten[22], advocacy to access needed service and to address systems barriers to recovery initiation and maintenance are an expected part of the RC role.

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[19] AA Tradition Eight: "Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers."

[20] Efforts are underway to develop ethical guidelines specific to those providing peer-based recovery support services.

[21] AA Tradition Twelve: "Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities."

[22] AA Tradition Ten: "Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy."

Affiliation: Where brokering formal affiliations with other organizations as a sponsor is prohibited by Tradition Six[23], the RC may act on behalf of their agency to negotiate formal affiliations and collaborations with other organizations toward the goal of expanding local recovery support networks.

It can be seen from this review that significant differences exist between the roles of sponsor and recovery coach. These distinctions are important for several reasons.

1. Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) on time one is working as an RC is a violation of Twelve Step Traditions and professionally inappropriate (beyond the scope of most agency RC job descriptions and explicitly prohibited in many).
2. Performing sponsorship functions through the RC role could weaken local sponsorship practices and diminish community recovery support resources by replacing such natural support with the formal support of local treatment agencies.
3. Seeking reimbursement for sponsorship functions performed by a recovery coach is, at best, a poor stewardship of community resources and, at worst, fraud.
4. Role ambiguity and conflict resulting from a mixing of sponsorship and RC functions could inflict injury on clients/families, service workers, service agencies, and the community.
5. The RC role represents a form of connecting tissue between professional systems of care and indigenous communities of recovery and between professional helpers and sponsors; when those filling this role abandon this middle ground and move too far one direction or the other, that connecting function is lost (Bass & Calori, 2006).

## How Recovery Coaching Differs from Addiction Counseling

The recovery coach (RC) role sits among multiple roles on the recovery support continuum. Its functions are positioned between those of the sponsor and those of the addictions counselor, with key aspects of the RC role approaching the activities of those performed by sponsors and counselors. The RC role is distinguished from the addiction counselor role by the following role dimensions.

Service Goals and Timing: Where the primary role of the addiction counselor is in facilitating the process of recovery initiation for those who have reached a point of readiness to change, the RC's role (at this point in its historical development) is more focused on preparing the soil in which recovery can grow, using motivational enhancement strategies to regularly tip the scales of ambivalence toward a recommitment to recovery, transferring credibility from themselves to other helping professionals, and facilitating the ongoing lifestyle reconstruction that is crucial for successful long-term recovery.

Education and Training: Where most addiction counselors today are formally educated and institutionally credentialed via certification or licensure, the legitimacy and credibility of the RC springs from experiential knowledge and experiential expertise. The former involves direct experience with personal/family addiction and recovery, and the latter requires demonstrated ability to use this knowledge to affect change in self or others. This does not explicitly require that all RCs be recovered or recovering, but it does require that those filling this role know addiction and recovery from close proximity. The credential of experiential expertise is granted through the community "wire" or "grapevine" (community story-telling) and is bestowed only on

[23] AA 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."

those who have demonstrated their wisdom and skills as a recovery guide within the life of the community. Some RCs may be professionally trained, but their authority comes not from their preparation but from their character, relationships, and performance within the community (White and Sanders, 2004; Borkman, 1976).[24]

Use of Self: Where self-disclosure has become increasingly discouraged in the addictions counselor role, it is an important dimension of the RC role. The use of self (using one's own personal/cultural experiences to enhance the quality of service) is an inherent part of both the RC and addictions counselor roles, but the use of self by the latter has changed dramatically over the past four decades. In the "paraprofessional" era of addiction counseling (the 1950s-early 1970s), disclosing one's status as a recovering person and using selected details of one's personal addiction/recovery history as a teaching intervention were among the most prominent counselor interventions. This dimension of the counselor role was based in great part on the role these dimensions played in successful sponsorship within AA Through the 1980s and 1990s, such disclosure came to be seen as unprofessional and a sign of poor "boundary management." Where self-disclosure by the counselor has been discouraged or discredited, such self-disclosure has been re-elevated in the role of the recovery coach. The recovery coach uses his or her own story and ability to connect the client to the stories of others as a means of offering testimony to the reality and power of recovery and to offer the recovery neophyte guidance on how to live as a person in recovery.

Service Relationship: Both the addiction counselor and RC service relationships are fiduciary relationships: both imply specialty knowledge and skills, governance by legal and ethical mandates and an inequality of power in the service relationship that can be misused for emotional, financial or sexual exploitation. In examining the different relationships that clients experience with sponsors, RCs and counselors, the differences are not in power equality versus inequality but in degrees of power inequities (there is vulnerability within all three relationships) and degrees of vulnerability for injury (with that vulnerability progressively increasing across the sponsor, RC, and addiction counselor service continuum). The fact that the RC maintains a much less hierarchical relationship with most of his or her clients and maintains these relationships for much longer periods of time suggests that the ethical standards that guide the addiction counselor may not be appropriate to guide the RC service relationship. For example, such behaviors as accepting a gift from a client, maintaining phone or email contact with a client following his or her discharge from treatment, having dinner with a client, and giving a client a ride to a recovery support meeting would now be deemed unacceptable in the counselor-client relationship, but may be accepted and crucial to the delivery of long-term recovery support services.

Locus of Service Delivery: Where the addictions counselor asks, "How do I get this individual into and through a treatment experience?" the recovery coach asks, "How can the process of recovery be initiated and anchored within the client's own natural environment?" or, when facing an environment in which recovery is improbable, "What alternative environment is available within which the client can initiate and sustain a life in recovery?" Where counseling services tend to be institution- and office-based, the preferred site for the delivery of recovery coaching is in the client's world. Neighborhood-based and home-based service delivery is the norm for the RC.

Service Philosophy (Ecology of Recovery): Where the addictions counselor and the larger professional treatment team tend to view recovery as something that happens inside the client and focuses on breaking the physical person-drug relationship, modifying the client's perceptions, thoughts, and actions, RCs tend to see recovery as something that happens in

[24] The recovery coach is closer to the sponsor in this regard than today's addiction counselor, in that the former roles are more experientially based. The sponsor's source of authority (what enables the sponsor to provide help) is not professional training but "personal experience and observation" (AAWS, Inc, 1983, p. 10). The same could be said for the RC, although the RC does draw upon specialized training befitting their role.

one's relationship with self, God, family and community. RCs devote considerable time to modifying the client's environment to one that is recovery conducive. This is done through a greater focus on family and social systems interventions, efforts to stimulate and support abstinence-based processes of cultural renewal and work to expand indigenous recovery support structures within the client's environment. The RC role demands much greater skills in community development and community organization than does the addiction counselor role.

Duration of Contact: Where the addiction counselor has a relationship characterized by a clear beginning, middle and end (spanning an ever-briefer period of time), the RC is expected to sustain contact with most clients for months and years following the completion of primary treatment. The purpose of this contact is to provide ongoing contact (check-ups) and support, stage-appropriate recovery education, assertive linkage to communities of recovery, active problem solving of obstacles to recovery and, when needed, early re-intervention.

Core Competencies: Where the core competencies of addiction counseling include knowledge of addiction and skills to perform such clinically-oriented functions as screening, assessment, treatment planning, individual/group/family counseling, clinical documentation and referral, the core competencies of the RC are much more oriented toward a knowledge of the long-term recovery process and indigenous recovery support systems and such functions as crisis intervention, client engagement, motivational enhancement, linkage to treatment resources, recovery education, client/family linkage to indigenous communities of recovery, early re-intervention, community resource development, and policy advocacy.

Service Delivery Framework: Where the addiction counselor utilizes a problem generated from the assessment data to generate a professionally-directed treatment plan, the RC facilitates the development of a client-generated recovery plan (master plan and regular updates) that is much broader in scope and more community- and recovery-focused than traditional treatment plans (Borkman, 1997).

Service Language: Where the addiction counselor teaches the client a new language (e.g., organizing metaphors drawn from a particular treatment philosophy) with which the client can construct a recovery-based personal story, the recovery coach tends to use the client's own language and the language of the client's culture to help construct such stories.

Non-possessiveness: One final way that the RC role differs from both the sponsor role and the addiction counselor role is the dimension of non-possessiveness. Where the sponsor and counselor are prone to take "ownership" of an individual (e.g., "my sponsee" "my client"), the RC encourages those they work with to fully engage with other sources of recovery support. The "prize" to which the RC role is affixed is not the adoration and eternal gratitude of those they have coached, but the recovery of these individuals within a broad network of recovery support relationships.

## A Role Collaboration Case Study

This essay has sought to distinguish the roles of the addiction counselor, recovery coach and sponsor within the engagement, treatment, and recovery processes. In closing, we will explore how these roles complement one another in the lives of people seeking recovery and how these roles blend differently according to each client's problem severity/complexity and degree of recovery capital. The following case study illustrates how such collaboration occurs in real life.[25]

> Ms. C. was a 22 year-old African American woman when her delivery of a cocaine-exposed infant brought her to the attention of the state child protection agency. Ms. C.'s problems were numerous, severe, and chronic. In addition to her history of drug

[25] This case study is a composite drawn from the author's work as evaluator of Project SAFE, an innovative, gender-specific treatment program that integrated the resources of multiple agencies into a sustained recovery management team (See White, Woll & Webber, 2003). All identifying information in this composite has been altered.

dependence, she had a history of psychiatric illness (diagnosed at different times as depression, bipolar disorder and borderline personality) and a history of innumerable encounters with authority figures and coercive institutions. Ms. C. was a survivor of childhood sexual abuse with multiple traumagenic factors (early age of onset, long duration, multiple perpetrators, perpetrators drawn from within the family/kinship network, failure of maternal protection following disclosure) and had a history of turbulent relationships with men, distrust and hostility towards other females, and what she later self-described as "addiction to chaos".

In response to what was viewed as "intergenerational transmission of substance dependence and child neglect", the child welfare authorities threatened to take custody of Ms. C.'s baby if she did not enroll in and successfully complete addiction treatment. Ms. C. informed the workers in less than delicate language that her baby was being cared for by her grandmother, that treatment was for "losers" and that she wasn't going to do any of the things being demanded of her. In response, the workers, with little expectation of positive outcome, placed Ms. C. on a "contact list" for outreach services provided through a new multi-agency consortium serving addicted women and their children.

Jean, the assigned recovery coach, made repeated efforts to engage Ms. C. Jean was able to work through considerable resistance using her own recovery story and her knowledge of the neighborhood culture to facilitate relationship building. What she saw in Ms. C. was not pathology but a "miracle of survival"—a "diamond in the rough." Jean slowly developed a relationship with Ms. C., primarily through sustained listening, brief self-disclosures, responses to occasional crises and an unrelenting process of checking in via phone calls and an occasional "thinking of you" card. Where everyone else in Ms. C.'s life was threatening her with what was going to happen if she didn't change, Jean offered "living proof" of the potential to change and the encouragement and expectation that Ms. C. would change. After seven weeks of Jean's "recovery priming," Ms. C. agreed to be assessed for entry into an intensive outpatient treatment program for women. When Ms. C. was later asked how her recovery started, she responded, "I couldn't get rid of that woman [Jean]. I think she would have followed me into Hell and brought me back. I guess in some ways, she did."

In the early transition into treatment, Jean provided traditional case management services to remove obstacles to participation (e.g., transportation) and served as mediator between Ms. C., Ms. C.'s primary counselor and the other women in treatment with whom Ms. C. had numerous verbal altercations. In addition to helping defuse the chaos in Ms. C.'s environment, Jean intervened daily to decompress the latest emotional outburst and threat to leave treatment, while simultaneously convincing program staff that Ms. C. should not be thrown out of treatment for early episodes of drug use and her verbal outbursts. During this middle engagement stage, Jean and the addictions counselor worked through their own issues of competition and conflict (sparked in part by Ms. C.'s skills at splitting them) and somehow kept Ms. C. involved in treatment.

In the late engagement stage, the street-hardened veneer of Ms. C. cracked as she "bared her soul" and grew increasingly dependent upon her primary counselor. In the weeks that followed, Ms. C. explored every corner of her life and began to develop hope for her future. Jean stayed involved through this period but took on a secondary role in all the work on "issues" that was going on. The counselor built on the platform of hope that Jean had constructed and helped Jean extend her fragile capacity for trust. This stage was followed by Ms. C. finally remaining drug free, disengaging from drug-enmeshed relationships, continuing to explore her life story, and bonding with other women in treatment. Jean continued to provide daily encouragement and offer normative information on the experience of early recovery. Jean also became the human link between Ms. C. and her initial exposure to N.A. and A.A. During this early exposure, Ms.

C. resisted all encouragements to get a sponsor but did finally get a sponsor after several months of making meetings.

As the sponsor relationship strengthened, Jean's role shifted to one of lifestyle reconstruction (helping Ms. C. establish a sober lifestyle in the community), periodic crisis intervention (usually involving an encounter with a man), and assistance in preparing for Ms. C.'s caretaking of her daughter. A critical role in the latter was Jean's support of the grandmother who seemed to be sabotaging Ms. C.'s efforts to re-assume care of her child. Involving other family members helped the grandmother to in turn help Ms. C. assume her maternal role. While the sponsor remained focused on Ms. C.'s early recovery experience, Jean focused on the periphery of this process, addressing such issues as safe and drug-free housing, parenting training/coaching, and helping Ms. C. get further disentangled from people and institutions that reinforced her "sick role."

Eight months following her admission, Ms. C. "graduated" from treatment and her daughter moved in with her. Jean's primary role here was one of parental coaching and building in supports (e.g., child care arrangements) that allowed Ms. C. to continue attending recovery support meeting activities. During this period, the addiction counselor's role ended (other than an occasional phone consult or single session to respond to some emotional crisis), and the role of the sponsor dramatically increased. The sponsor played numerous functions at this time. She helped lead Ms. C. into the local Twelve Step recovery community, coaxed Ms. C. through the Twelve Steps, and offered concrete advice about how not to "pick up". The sponsor assumed some of the earlier "lifestyle consultant" functions performed by the recovery coach and moved more to the emotional center of Ms. C.'s life. There were times Jean, Ms. C., and her sponsor met together at a local coffee shop during this period for a "progress meeting" and to re-clarify who was helping with what.

As Ms. C.'s recovery gained time and depth, Jean remained involved as a foundational source of support via periodic phone calls and home visits. When Jean was contacted by Ms. C. in a crisis, Jean encouraged Ms. C. to re-engage support from her family and sober friends, her sponsor and on a few occasions, her addiction counselor. As Ms. C.'s recovery stabilized through support of her sponsor, family and a new recovery-based relationship, Jean's contact reduced to a quarterly recovery checkup.

Interestingly, there was one additional transition in which Jean later played a significant role. Ms. C. became involved in a faith-based recovery ministry two years into her recovery and became increasingly active in the church that sponsored this ministry. As this occurred, her N.A. participation was important but no longer the centerpiece of her recovery. Ms. C. found herself experiencing a loyalty conflict between N.A. and her N.A. sponsor on the one hand, and her church and her pastor on the other. Jean affirmed for Ms. C. that this was not an either/or choice, and that she needed to create a combination of supports that worked for her and to be assertive in communicating that preference to others who were trying to define what her recovery needed to look like. As an advocate of recovery, but not a particular flavor of recovery, Jean was in a position to help Ms. C. focus on what worked best for her. As a result, Ms. C. was able to work out a style that utilized both recovery support structures.

A few years later and in between the annual call to Ms. C. that Jean was now making, Ms. C. called Jean to announce that she wanted Jean's job. Ms. C. had decided it was time to go to work, and there was only one job she'd ever seen that she really wanted to do and that was to work as a recovery coach helping women like herself. Ms. C. enrolled in school and later began working in the same system in which she was once admitted as a client with a "poor prognosis for recovery." Imagine the power of her story when delivered to a client who unknowingly declares to her, "But you couldn't possibly understand." Telling her story today is possible because three different but complimentary roles were there when she needed them.

We must be careful in our training and supervision of those working as recovery coaches that we do not commercialize Twelve Step service work and that we do not replace the "language of the heart" with professional jargon or replace experiential authenticity and intuitive helping abilities with clinical technique.[26]

**Summary**

This essay has tried to identify those qualities that distinguish the peer-based recovery support specialist (referred to in this paper as "recovery coach") from two allied roles: the peer guide within recovery mutual aid groups (referred to generically in this paper as "sponsor") and the role of the professional addictions counselor. As with any new service role, the RC role takes on a different character within different organizations and cultural communities. At the moment, the fact that the RC role is defined somewhat differently between agencies may be less important than having the role clearly defined within each agency. A clearer definition of the role will emerge from the collective experience of those working as and supervising RCs. This evolving role needs to be supported in a number of critical ways via key technologies, including:

- further role definition and standards to assure its peer integrity,
- model criteria for screening, interviewing and hiring RCs,
- model compensation and benefit packages and career ladders,
- RC orientation, training and supervision models,
- a model RC code of ethical conduct, and
- manualized, evidence-based RC service protocol.

In Texas, efforts are underway to develop an association of peer-based recovery support organizations. The purpose of the association would be to generate core principles, service methods and ethical standards that would define the unique nature of these services (Bass & Calori, 2006). Other states are utilizing or exploring the use of their independent addiction counselor certification board to assume responsibility for developing and administering certification standards for recovery coaches. Recovery advocates raise concerns that, if given governance over the recovery coach role, traditional certification boards will over-emphasize educational degrees and de-emphasize recovery experience and natural helping abilities (PRO-ACT Focus Group, April, 2006).

The fate of the recovery coach role will be influenced by the forces that shaped those roles that came before it: the future evolution of professional treatment organizations and recovery mutual aid societies, evolutions in the design of addiction treatment (e.g., from acute care models to models of sustained recovery management), trends in service reimbursement policies, and what may be the inevitable professionalization of the RC role. It will be hard to retain the role's recovery focus, but history tells us that if this focus is lost, new roles will eventually emerge to recapture this focus. At the moment, the role of RC holds promise in elevating long-term recovery outcomes through the provision of pre-recovery, recovery initiation/stabilization and recovery maintenance support services and by expanding the quantity and variety of recovery support services in local communities. To fulfill that potential, those serving as recovery coaches will need to carefully distinguish their functions from those of the sponsor and the addiction counselor while exhibiting deep respect for these allied roles.

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[26] See Caplin, 2000, p. 22-23 for a discussion of the dangers of professionalizing peer helpers.

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## The Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates

**William White, MA and Ernest Kurtz, PhD**

**ABSTRACT**

*The study of alcohol and other drugs (AOD) is historically marked by three stages: 1) the investigation of AOD-related social and personal pathologies, 2) the development of personal and social interventions aimed at resolving AOD problems, and 3) a focus on the prevalence and patterns of long-term recovery from AOD problems. This essay honors this transition from addiction and treatment paradigms to a recovery paradigm by exploring the growing varieties of pathways and styles through which people are resolving serious and persistent AOD-related problems. A review of scientific and mutual aid literature is used to catalogue variations in:*

- *scope of recovery (primary and secondary chemical health and global health),*
- *depth of recovery (partial, full, and enriched),*
- *types of recovery (abstinence-based, moderation based, medication assisted),*
- *context of recovery initiation (solo, peer assisted, treatment assisted),*
- *frameworks of recovery initiation (religious, spiritual, secular),*
- *temporal styles of recovery initiation (transformative change, incremental change, drift),*
- *recovery identity (positive, neutral, negative),*
- *recovery relationships (acultural, bicultural, and enmeshed styles; virtual recovery),*
- *recovery stability/durability (At what point does present remission predict future remission?), and*
- *recovery termination (Is recovery ever completed?).*

*After exploring the wide diversity of recovery styles and experiences that exist within Twelve-Step fellowships and other recovery mutual aid societies, the article explores the implications of the wide diversity in recovery experiences to the design and conduct of addiction treatment.*

**Keywords**: addiction recovery, natural recovery, transformative change, stages of change, virtual recovery, religion, spirituality, and secularity.

## ADDICTION, TREATMENT, AND RECOVERY PARADIGMS

Alcohol- and other drug-related (AOD) problems constitute a significant public health problem within American and world history (Lender & Martin, 1982; Musto, 1999; Courtwright, 2001). Responses to these problems over the past two centuries reflect three organizing paradigms. From the late eighteenth century through the era of alcohol prohibition, pathology provided an organizing framework, whether religiously or medically conceived. The pathology paradigm fueled the debate over whether alcoholism was a sin or a sickness; guided studies of the incidence, prevalence and personal/social costs of AOD problems; and sparked the sustained search for the etiological roots of these problems. The hope upon which the pathology model was built was that knowledge of the scope and sources of AOD problems would generate specific solutions to these problems in the same way isolating and attacking particular pathogens had earlier led to the elimination or control of many infectious diseases. While failing to achieve this ultimate goal to-date, the pathology model has made significant contributions to our understanding of the multidimensional processes that interact to initiate and sustain addiction.

The failure to find the singular pathogen underlying AOD problems led to the testing of numerous strategies and techniques of intervention, both social and personal. To this day, the intervention model buttresses multi-billion-dollar industries aimed at preventing drug use, controlling drug supplies, punishing drug offenders, and treating those with severe AOD problems. The intervention model assumes that the scientific evaluation of AOD-related social policies and biopsychosocial interventions will reveal the most effective prevention, intervention, and control strategies, and that those strategies that can be best matched to particular communities, demographic/clinical subpopulations, and individuals. This model has generated significant new understandings that are sparking widespread calls to bridge the gap between clinical research and clinical practice in addiction treatment.

The historical intractability of AOD problems at a societal level has led to disillusionment with the pathology and intervention paradigms and a recent shift in focus toward resilience and recovery (Morgan, 1995a; Elise, 1999; White, 2000, 2004a). As early as 1984, Edwards was calling for the field to explore the "natural processes of recovery." This was followed by calls for "recovery-oriented psychotherapy" (Zweben, 1986) and "recovery-sensitive counseling" (Morgan, 1995b). The recovery paradigm focuses on at-risk individuals, families, and communities who have avoided the development of severe AOD problems and the lives of individuals, families, and communities with severe AOD problems who have successfully resolved or are resolving these problems. Advocates of this model suggest that studying the lived solutions to AOD problems will reveal principles and strategies upon which broader, more effective social policies and professional interventions can be built (Morgan, 1995a; White, 2005).

Knowledge about AOD problems is substantial, but comparatively little is known from the standpoint of science about the long-term solutions to these problems. In recent epidemiological studies of individuals who once met criteria for alcohol

dependence, 63% to 75% no longer met dependence criteria at the time they were surveyed, suggesting a substantial long-term recovery rate (Helzer, Burnam, & McEvoy, 1991; Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). The Workgroup on Substance Abuse Self-help Organizations (2003) estimates the total U.S. membership of recovery mutual aid groups at more than 1.6 million people and reports that more than six million adults each year have some contact with these groups. In spite of a substantial body of recovery experience in the U.S., the addictions field does not draw its primary knowledge base from this source. Today, addiction professionals routinely assert the existence of multiple pathways of recovery, but from the standpoint of science, we know little about such pathways. As addiction treatment interventions become ever briefer, treatment professionals have less and less contact and knowledge of the long-term recovery process.

AOD problems arise out of quite different personal, family, and cultural contexts and unfold in variable patterns and trajectories. These same forces generate heterogeneous recovery experiences. The goals of this paper are to: 1) conceptually map the diverse patterns and styles of AOD problem resolution, 2) introduce a lexicon through which such variations can be described, and 3) explore the implications of the diversity of recovery experience for the design and conduct of professional interventions into such problems. This conceptual map is based primarily on scientific studies on the course of AOD problems in community and in clinical samples. The literature of multiple recovery mutual aid societies and biographical and autobiographical depictions of recovery are also used to illustrate key findings. We hope this preliminary recovery map will spark new scientific studies of the prevalence, patterns, stages, and personal styles of long-term recovery from AOD problems.

## RECOVERY DEFINITION

*Recovery* is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for *substance abuse* or *substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational, and occupational health.

AOD problems vary in their course, including adverse reactions to a single episode of AOD-intoxication, problems that span only a few months or years, and problems that span significant periods of one's life. Such problems also vary in their intensity and overall severity, including:

- subclinical problems (transient AOD problems that do not meet DSM-IV criteria for abuse or dependence);
- AOD problems meeting DSM-IV criteria for substance abuse — Clinically significant impairment marked by one or more of the following in a 12-month time period: repeated substance use that results in failure to perform major role obligations, repeated use in situations that are physically hazardous, repeated substance-related legal problems, and continued substance use in spite of adverse AOD-related problems; and
- AOD problems meeting DSM-IV criteria for substance dependence — Clinically significant impairment marked by at least three of the following in a 12-month period: tolerance, withdrawal, loss of control (erosion of volitional control over quantity and duration of use), failed efforts to cease or reduce use; significant time involved in drug procurement, drug use, and recovery from drug effects; social, occupational, or recreational activities forsaken or reduced due to drug use; and continued use in spite of adverse physical or psychological problems

caused by substance use (American Psychiatric Association, 1994).

The term *recovery*, because of its medical connotations, is most applicable to the process through which severe and persistent AOD problems (meeting DSM-IV criteria for substance abuse or dependence) are resolved. Terms such as *quitting*, *cessation,* and *resolution* more aptly describe the problem-solving processes of individuals who have transient and less severe AOD problems. Recovery implies reversal of a greater level of debility and a more involved and enduring problem-solving process (White & Scott, draft manuscript). Our continued discussion of varieties of recovery experience will focus on these more severe forms of AOD problems.

The term *family recovery* conveys the processes through which family members impacted by severe and persistent AOD problems individually and collectively regain their health. Family recovery involves enhanced health across three dimensions: 1) individual family members, 2) family subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships), and 3) the family as a system (redefinition of family roles, rules, and rituals; recovery-conducive boundary transactions with people and institutions outside the family) (White, 1996). The recovery of an addicted family member can destabilize and threaten the survival of the family unit if professional and social supports are not available to soften what Stephanie Brown and Virginia Lewis (1999) have christened the "trauma of recovery" (See also Rouhbakhsh, Lewis, & Allen-Byrd, 2004).

## RECOVERY PREVALENCE

Elaborate systems exist to measure the subtlest of changes in the prevalence of AOD use and its consequences, but no similar system exists to measure the incidence and prevalence of recovery from AOD problems. However, individual researchers have conducted long-term treatment follow-up studies and community surveys over the past 25 years that reveal significant recovery rates: 41% (Ojesjo, 1981); 63% (Helzer, Burnam & McEvoy, 1991); 72% (Dawson, 1996); 30% (Schutte, Nichols, Brennan, & Moos, 2001); 59% (Vaillant, 2003); and 48% (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Factors such as differing demographic and clinical characteristics of study participants and different definitions of recovery influence variations in reported recovery rates.

## THE SCOPE AND DEPTH OF RECOVERY

Recoveries from addiction can differ in their scope (the range of measurable changes) and depth (degree of change within each measured dimension). Aborting a destructive relationship with a particular drug or combination of drugs is at the core of addiction recovery, but recovery experiences can range from complete cessation of AOD use in an otherwise unchanged life to a complete transformation of one's personal identity and interpersonal relationships.

There are quite varied trajectories in the relationship between primary and secondary drug use among people seeking recovery from substance use disorders. One pattern of drug dependence can be aborted while a co-occurring pattern continues. For example, there are high rates of nicotine dependence among adults and adolescents before and after treatment for dependence upon alcohol, opiates, cocaine, and cannabis (Maddux & Desmond, 1986; Myers & Brown, 1990; Hughes, 1995, 1996; Bien & Barge, 1990; Hoffman & Slade, 1993).

A second pattern involves the escalation of secondary drug use following cessation of primary drug use, e.g., an increase in alcohol or cocaine use following the cessation of heroin use. Such drug substitution is a common problem in treated adults and adolescents, particularly among those with a history of polydrug use (Vaillant, 1979; Edwards, Duckitt, Oppenheimer, Sheehan, & Taylor, 1983; Toneatto, Sobell, Sobell, & Rubel, 1999; Maddux & Desmond, 1980, 1981, 1992; Anglin, Almong, Fisher &

Peters, 1989; Simpson & Sells, 1990; Carmelli & Swan, 1993).

A third pattern involves individuals who use secondary drugs therapeutically during early recovery to manage acute and post-acute withdrawal and to help ameliorate the psychological stresses of early recovery (e.g., heroin users consuming cannabis following opiate abstinence to prevent relapse) (Willie, 1978; Waldorf, 1983; Biernacki, 1986; Copeland, 1988). In this pattern, secondary drug use ceases or decelerates within the first two years of recovery (Waldorf, 1983; Vaillant, 1979; Copeland, 1988; Bachus, Strang, & Watson, 2000).

The ability to understand when drug substitution is an effective, time-limited strategy for managing early recovery (requiring professional understanding, if not tolerance) and when drug substitution is a mutation of the existing problem (requiring prevention, early intervention, or focused treatment) is an important research agenda. Some investigators have found that secondary drug use is more likely to be problematic for persons with family histories of AOD problems, those who begin AOD use at an early age, and those who experience problems with a secondary drug before developing their primary addiction (Simpson & Sells, 1990; Maddux & Desmond, 1992). Also needed is a greater understanding of how sequential drug problems are resolved over time. The factors that contribute to the cessation of co-occurring dependencies or secondary drug use may differ from those factors associated with the cessation of primary drug use (Downey, Rosengren, & Donovan, 2000).

The scope of recovery can extend far beyond altered patterns of primary and secondary drug use. Historically, the definition of recovery has shifted from a focus on what is deleted from one's life (alcohol and other drugs, arrests for criminal acts, hospitalizations) to what is added to one's life (the achievement of health and happiness). This shift is reflected in such terms as *mental sobriety* (Mental Sobriety, 1946) and *emotional sobriety* — a phrase A.A. co-founder Bill Wilson coined to describe a state of emotional health that far exceeds the achievement of not drinking. Wilson defined emotional sobriety as "real maturity . . . in our relations with ourselves, with our fellows and with God" (Wilson, 1958). This broadened vision of recovery is also reflected in the term *Wellbriety* that is currently being used within the Native American recovery advocacy movement to depict recovery as the pursuit and achievement of physical, emotional, intellectual, relational, and spiritual health, or "whole health" (Coyhis, 1999; *Red Road to Wellbriety*, 2002). Wellbriety within the Native American context is also related to a new set of core *recovery values*: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

Because severe and persistent AOD problems impact many areas of life functioning, recovery from such problems must be measured across multiple *zones* (or *domains*) *of recovery*: 1) the relationship(s) with the substance(s) for which one previously met DSM-IV criteria for abuse or dependence; 2) the presence, frequency, quantity, intensity, and personal and social consequences of secondary drug use; 3) physical health; 4) psychological/emotional/ontological health; 5) family/relational health; and 6) lifestyle health, e.g., a developmentally appropriate, pro-social style of work and leisure (White, 1996). Seen as a whole, the goal of recovery is what we refer to as *global health*.

Like that of other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of *full recovery* (complete and enduring cessation of all AOD-related problems and the movement toward global health) or a state of *partial recovery* (Jorquez, 1983). The term *partial recovery* can convey two different conditions: 1) a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems; or 2) the achievement of complete abstinence or stable moderation, but the failure to achieve

parallel gains in physical, emotional, ontological, relational, or occupational health. Partial recovery can constitute a permanent state, a stage preceding full recovery, or a hiatus in AOD problems with eventual reversion to a previous or greater level of problem severity.

Falling between the parameters of no recovery and full recovery are individuals who cycle in and out of periods of moderate use, problematic use, and abstinence (Hser, Hoffman, Grella, & Anglin, 2001). A recent review of alcoholism treatment outcome studies drew three major conclusions: 1) treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third of those treated, 2) substance use (measured by days of use and volume of use) decreases by an average of 87% following treatment, and 3) substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). People who are constitutionally incapable of permanent sobriety at particular points in their lives may achieve *partial recovery* — significant decreases in AOD-related problems, improved levels of health and social functioning, and significant reductions in the costs and threats they pose to the larger community (Zweben 1996).

Partial recovery is reflected in individuals who cycle through multiple episodes of treatment, recovery initiation, and relapse (Scott, Foss & Dennis, 2005; Dennis, Scott, Funk & Foss, 2005). Such cycling is evidence that recovery is not fully stabilized, but the continued help seeking within such cycles also suggests that addiction is no longer stable. Cycling in and out of recovery (with reduced frequency, intensity, and duration of use episodes) can be a precursor to stable recovery or a chronic state.

Partial recovery can also refer to residual levels of impairment that continue after the cessation or deceleration of AOD use. While most recovering alcoholics establish levels of personal and family functioning comparable to non-alcoholics (Moos, Finney, & Cronkite, 1990; Chapman, 1987), early recovery can be marked by poor levels of adjustment, e.g., depression, anxiety, poor self-esteem, guilt, and impaired social functioning (Kurtines, Ball, & Wood, 1978; Polich, Armor, & Braiker, 1980; Gerard & Saenger, 1962; Behar, Winokur, & Berg, 1984). De Soto and colleagues (1985) distinguished recovery status by length of recovery in a study of 312 members of Alcoholics Anonymous. They concluded that: 1) the early months and years of recovery from alcoholism are marked by continued impairment of emotional and social functioning, 2) these symptoms continue to improve and remit over the first ten years of recovery, and 3) some residual symptoms of cognitive dysfunction may continue in long-term recovery. The achievement of only a partial reversal of alcohol-related cognitive impairments is most common in alcoholics who began their recoveries after long drinking careers (Goldman, 1983; Schutte, 1994, 2001). The principle that global health and functioning improve with earlier onset of recovery and length of sobriety is further confirmed in follow-up studies of persons recovering from cocaine addiction (Selby, Quiroga, Ireland, Malow, & Azrin, 1995).

Some individuals experience changes so profound across these zones of recovery that they come to view addiction and recovery as “gifts” that have brought a depth of experience and meaning far superior to their pre-addiction lives. Such individuals achieve an *enriched state of recovery*. This enriched state of recovery is evident across recovery traditions:

> *The walls crumpled — and the light streamed in. I wasn’t trapped. I wasn’t helpless. I was free, and I didn’t have to drink to “show them.” This wasn’t “religion” — this was freedom! Freedom from anger and fear, freedom to know happiness and love.* (From *Alcoholics Anonymous*, 1976, p. 228.)

> *It is impossible to put on paper all the benefits I have derived . . . physical, mental, domestic, spiritual, and monetary. This is no idle talk. It is the*

*truth. (*From *Alcoholics Anonymous*, 1976, p. 481.)

*My life is well-rounded and I am becoming a more comfortable version of myself, not the neurotic, boring person that I thought I would be without drugs…..I have a way to live cleanly, honestly and comfortably. I have all I need.* (From *Narcotics Anonymous*, 1988, p. 262.)

*It's been a very long, long struggle but worth every single minute of it. I'm really happy to be alive, and life is truly great and wonderful for me right now.* (Women for Sobriety member, From Kirkpatrick, 1986, p. 258.)

*Back in 1970 I found myself dying from the abuse of my body….The Creator had something he had for me to learn. First, I had to learn who he was. Then I had to learn who I was. I began to visit with my Elders….I had to come to grips with who I am as an Indian, as being a castaway, as being an unloved person. The Creator has love for each of us but we have to find that foundation.* (From *Red Road to Wellbriety*, 2002, p. 187.)

A final scope-and-depth dimension of recovery involves individuals who are engaged in concurrent or sequential recovery processes from two or more conditions or experiences, e.g., developmental trauma, psychiatric illness, AIDS. The overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders might be described as *serial recovery*.

## PROBLEM SEVERITY AND RECOVERY CAPITAL

Recovery can occur at different stages of problem progression. There are patterns of *high-bottom recovery* among people who have not yet suffered severe losses related to their AOD use. There are also patterns of *low-bottom recovery* achieved by individuals in the latest stages of addiction who have experienced severe personal and social disintegration and anguish before achieving stable recovery (High Bottom, 1949).

In addition to the degree of problem severity, one's recovery capital influences one's prognosis for recovery. *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). The interaction of problem severity and recovery capital shapes both the prospects of recovery and the intensity and duration of resources required to initiate and sustain recovery.

## PATHWAYS AND STYLES OF RECOVERY

The phrase *pathways of recovery* refers to different routes of recovery initiation. This phrase recognizes the varieties of ways people successfully resolve AOD problems. One of the earliest origins of this notion of paths and choices of recovery frameworks was A.A. co-founder Bill Wilson's 1944 observation that "The roads to recovery are many" (Wilson, 1944). *Cultural pathways of recovery* are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. Such culturally prescribed avenues might be a product of:

- developmental consciousness (e.g., something to be resolved through maturation and assumption of adult role responsibilities),
- medical consciousness (e.g., response to an alcohol-related health problem),
- religious consciousness (e.g., conversion to and/or affiliation with an abstinence-based faith community), or
- political consciousness (e.g., rejection of alcohol as a "tool of genocide").

The phrase *styles of recovery* depicts variations in beliefs and recovery support rituals that exist within particular pathways of recovery. For example, Twelve-Step

programs constitute one of the major pathways of recovery from addiction, but the close observation of several Twelve-Step groups would reveal wide variation in styles of "working the program," e.g., patterns of meeting attendance, approaches to "Step work," conceptualizations of "Higher Power," and utilization of sponsors.

### ABSTINENCE-BASED, MODERATION-BASED, & MEDICATION-SUPPORTED RECOVERIES

One of the variations in recovery from substance use disorders involves differences in the ways in which one's relationship with psychoactive drugs is changed. The scientific literature on the resolution of AOD problems documents three such variations. *Abstinence-based recovery* has historically been the culturally prescribed approach to the resolution of severe AOD problems. This approach, which has guided mainstream addiction treatment in the United States in the modern era, calls for complete and sustained cessation of one's primary drug(s) and the non-medical use of other psychoactive drugs (with nicotine and caffeine historically excepted). Over the past several decades, scientific evidence has grown on moderated approaches to AOD problem resolution. *Moderation-based recovery* (the sustained deceleration of AOD use to a subclinical level — continued AOD use that no longer meets DSM-IV criteria for substance abuse or dependence) has triggered great debates in America, spanning the 1976 Rand Report[1], the extended controversies over Mark and Linda Sobell's research at Patton State Hospital[2], and later controversies surrounding Moderation Management, a moderation-based mutual support group (Kishline, 1994). There has also been growing interest in *medication-assisted recovery* (the use of medically monitored pharmacological adjuncts to support recovery from addiction, e.g., detoxification agents, stabilizing agents, aversive agents, antagonizing agents, anti-craving agents, or psychoactive drugs prescribed for the treatment of co-occurring physical or psychiatric disorders).

Discussion of these approaches is best grounded in the finding that substance-use problems exist across a continuum of problem severity and that problem severity influences pathways of problem resolution. Abstinence-based and medication-assisted styles of recovery predominate in patterns of severe alcohol and drug dependence, whereas moderation-based styles of recovery predominate in individuals with lower problem severity and greater recovery capital (younger, married, employed, higher socioeconomic status, higher social support and social stability, positive marital and work relationships) (Finney & Moos, 1981; Polich, et al., 1980; Vaillant, 1983; Armor & Meshkoff, 1983; Edwards et al., 1983; Rosenberg, 1993; Dawson, 1996; Cunningham, Lin, Ross, & Walsh, 2000; Vaillant, 1996).

The moderated resolution of substance use disorders is well documented in general population surveys. Dawson (1996), in a community survey of treated and untreated adults who previously met DSM-IV criteria for alcohol dependence, found that in the year prior to the survey 49.9% were drinking but no longer met criteria for abuse or dependence (27.8% met criteria for alcohol abuse or dependence, and 22.3% were abstinent). Two other studies (one a Canadian national study and the other an Ontario study) used a broader definition of "alcohol problems" and found that 38% and

[1] The initial Rand Report included the finding: "…it appears that some alcoholics do return to normal drinking with no greater likelihood of relapse than alcoholics who choose abstention…" (Quoted in White, 1998). Controversies surrounding this report led to a second report that softened the initial report's findings.

[2] Drs. Mark and Linda Sobell published a series of scientific reports documenting that some alcoholics achieve controlled drinking (Sobell& Sobell, 1973, 1976, 1978). These reports were followed by a re-evaluation by Pendery, Matzman,& West (1982) that challenged the Sobell's findings and their professional integrity. The Sobell weathered blistering personal and professional attacks in spite of being later cleared of wrongdoing by two separate scientific panels (Dickens, Doob, Warwick, & Winegard, 1982; Trachtenberg, 1984).

62.7% (respectively) of those with alcohol problems had later resolved those problems via moderate drinking recoveries (Sobell, Cunningham, & Sobell, 1996). Moderated recovery at much lower rates of prevalence has also been noted in follow-up studies of those treated for alcohol dependence (Finney & Moos, 1981; Rosenberg, 1993; Vaillant 1996) and drug dependence (Levy, 1972; Willie, 1978; Harding, Zinberg, Stelmack, & Michael, 1980). Treatment outcome studies of adolescents have also found a subgroup of treated teens who "may evidence intermittent substance use, typically alcohol, but do not exhibit any ongoing alcohol-or-drug-related problems" (Brown, 1993).

Given the propensity for substance-related problems to wax and wane over time, one could rightly question whether subclinical use following addiction is sustainable. In the longest follow-up study of alcoholic men to-date (60 years), Vaillant (2003) found that 4% of inner-city men and 11% of college men sustained controlled drinking over the course of the follow-up. Most migrated from dependence to efforts at control to eventual abstinence. In the largest and most recent alcohol dependence and recovery prevalence survey (recovery defined as meeting DSM-IV alcohol dependence criteria prior to the last year but not meeting these criteria during the past year), 25% of those with prior alcohol dependence continued to meet dependence criteria, 27% were in partial remission (subclinical symptoms of dependence or presence of alcohol abuse), 12% were asymptomatic risk drinkers (drinking in a pattern predictive of risk for future relapse), 18% were low-risk drinkers, and 18% were abstainers (Dawson et al., 2005). As problem severity declines, the prevalence of moderated outcomes increases. This is most frequently noted in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood but later moderate their substance use (Fillmore, Hartka, Johnstone, Speiglman, & Temple, 1988).

Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting that moderation was an option for some problem drinkers, but not for "alcoholics" like themselves. The following two excerpts reflect their beliefs and attitudes about moderation-based recovery.

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason — ill health, falling in love, change of environment, or the warning of a doctor — becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention* (*Alcoholics Anonymous*, 1939, p. 31).

> *If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people!* (*Alcoholics Anonymous*,1939, p. 42).

Medication-assisted recovery continues to generate considerable controversy within the American culture, within communities of recovery, and within the professional addiction treatment community, in spite of evidence that attitudes toward medications as an adjunct to recovery may be softening (Rychtarik, Connors, Demen, & Stasiewicz, 2000). Influencing these shifts in attitudes are new pharmacological adjuncts in the treatment of alcohol dependence (e.g., naltrexone, acamprosate) and opiate dependence (e.g., clonidine, buprenorphine) (Vopicelli & Szalavitz, 2000).

One of the most widespread approaches to medication-assisted recovery is methadone maintenance treatment (MMT). There are an estimated 900,000 narcotic addicts in the United States and approximately 179,000 individuals enrolled

in MMT (Kreek & Vocci, 2002). The major health policy authorities in the United States have weighed in on MMT and have universally concluded that optimal dosages of methadone combined with psychosocial supports and administered by competent practitioners: 1) decrease death rates of opiate addicts by as much as 50%; 2) reduce transmission of HIV, hepatitis B, hepatitis C and other infections; 3) eliminate or reduce illicit opiate use; 4) reduce criminal activity; 5) enhance productive behavior via employment and academic/vocational functioning; 6) improve global health and social functioning; and 7) are cost-effective (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998; White & Coon, 2003). In spite of such evidence, misunderstanding and social stigma attached to MMT (the perception that MMT simply substitutes one addictive drug for another) leave many in methadone-assisted recovery hiding their recovery status and stories from their employers and co-workers, their friends, and even their own family members (Murphy & Irwin, 1992).

## THE CONTEXT OF RECOVERY INITIATION

The context in which people achieve remission from substance use disorders varies considerably and includes styles of solo recovery, treatment-assisted recovery, and peer-assisted recovery.

*Solo (natural) recovery* involves the use of one's own intrapersonal and interpersonal resources (family, kinship, and social networks) to resolve AOD problems without benefit of professional treatment or involvement in a recovery mutual aid community. This phenomenon is extensively documented in the professional literature under such descriptors as *maturing out* (Winick, 1962, 1964), *autoremission* (Vaillant, 1983; Klingeman, 1992), *self-initiated change* (Biernacki, 1986), *unassisted change* (McMurran, 1994), *spontaneous remission* (Tuchfield, 1981; Anthony & Helzer, 1991), *de-addiction* (Frykholm, 1985; Klingeman, 1991), *self-change* (Sobell, Sobell, & Toneatto, 1991), *self-managed change* (Copeland, 1988), and *natural recovery* (Havassey, Hall, & Wasserman, 1991). Natural recovery is, according to some studies, the most common recovery pathway (Fillmore, et al., 1988; Sobell, Sobell, Toneatto, & Leo, 1993; Cunningham, Sobell, Sobell, & Kapur, 1995; Cunningham, 1999; Sobell, et al., 1996), but the prevalence of this style declines as problem duration and severity increase. Natural recovery is a more viable pathway for people with shorter and less severe AOD problems and for those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell, et al., 1996; Larimer & Kilmer, 2000).

Natural recovery exists across the spectrum of drug choices (Biernacki, 1986; Waldorf, Reinarman, & Murphy, 1991; Klingeman, 1992; Shaffer & Jones, 1989; Cohen & Sas, 1994; Toneatto et al., 1999; Kandel & Raveis, 1989) and seems to be influenced by two age-related patterns: 1) a young adult pattern associated with maturation and the assumption of adult role responsibilities, and 2) a later-life pattern associated with cumulative consequences of alcohol and other drug use (Fillmore, et al., 1988; Sobell, Ellingstad, & Sobell, 2000).

Those who achieve natural recovery report multiple reasons for avoiding formal treatment institutions and mutual aid societies. These reasons include a desire to protect their privacy (aversion to sharing problems with others), a desire to avoid the stigma of being labeled, a belief that they can solve their problems without professional treatment, and a perception that treatment and mutual aid groups are ineffective or not personally suited for them (Tuchfield, 1981; Jordan & Oei, 1989; Cloud & Granfield, 1994; Burnam, 1997; Sobell, Ellinstad, & Sobell, 2000).

*Treatment-assisted recovery* involves the use of professional help in the initiation and stabilization of recovery. More than 1.5 million people are admitted to addiction treatment in the United States each year, but multiple factors complicate the relationship between treatment and recovery:

- Less than 10% of people with a substance use disorder in the U.S. seek professional treatment in a given year (SAMHSA, 2003), and only 25% of individuals with such disorders will receive treatment in their lifetime (Dawson et al., 2005).
- Addiction treatment in the United States is not a homogenous entity, but a network of service organizations with diverse philosophies and techniques that vary significantly in their effectiveness (Wilbourne & Miller, 2003).
- Those who seek professional treatment are characterized by high personal vulnerability (e.g., family history of AOD problems, lowered age of onset of use, traumatic victimization), greater problem severity and complexity, weaker social supports, fewer occupational opportunities, and less success (Polich, Armour, & Braiker, 1980; Room, 1989; Weisner, 1993; Tucker & Gladsjo, 1993; Cunningham et al., 1995).
- Recovery outcomes are compromised by high treatment attrition rates (more than 50%) (SAMHSA, 2002) and doses of treatment services (measured in days of care or number of sessions) that often fall below standards recommended for optimal effects (NIDA, 1999).
- Individuals may have experienced professional treatment, but such treatment may not have played a role in their later achievement of stable recovery.

In spite of such limitations, the vast majority of persons who suffer from substance dependence (in contrast to less severe AOD-related problems) enter recovery through the vehicle of professionally directed treatment (Cunningham 1999a,b, 2000). But this link is not as direct as one might think. Recent studies have shown that a significant portion of people with the most severe substance use disorders achieve stable recovery only after multiple treatment episodes spread over a number of years (Anglin, Hser, & Grella, 1997; Hser, Grella, Chou, & Anglin, 1998; Dennis, Scott, & Hristova, 2002), suggesting a possible cumulative effect of such interventions.

*Peer-assisted recovery* involves the use of structured recovery mutual aid groups to initiate and/or maintain recovery from AOD problems. Addiction recovery mutual aid structures of many varieties exist in the United States (see discussion below). Alcoholics Anonymous is the most widely used community resource for the resolution of alcohol-related problems (Room, 1989; Weisner, Greenfield, & Room, 1995), with 3.1% of U.S. citizens reporting having attended A.A. meetings sometime in their life for an alcohol problem and 1.5% reporting attendance at A.A. meetings for an alcohol problem in the past year (Room & Greenfield, 1993). Mutual aid involvement, as measured by studies of A.A., can play a significant role in the movement from addiction to recovery (Timko, Moos, Finney, & Moos, 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Emrick, Tonigan, Montgomery, & Little, 1993; Tucker, Vuchinich, & Gladsjo, 1994; Morgenstern, Labouvie, McCray, Kahler, & Frey, 1997; Humphreys, Wing, McCarty, Chappel, & Galant, 2004). This positive effect extends to:

- adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000; Kelly, Myers, & Brown, 2002),
- women and cultural minorities (Denzin, 1987; Caetano, 1993; Humphreys, Mavis, & Stoffelmayr, 1994; Kessler, Mickelson, & Zhoa, 1997; Bischof, Rumpf, Hapke, Meyer, & John, 2000; Winzelberg & Humphreys, 1999),
- persons experiencing substance use and psychiatric disorders (Meissen, Powell, Wituk, Girrens, & Artega, 1999; Ouimette, Humphreys, Moos, Finney, Cronkite, & Federman, 2001),

- persons using medications to support their recovery (Rychtarik, Connors, Demen, & Stasiewicz, 2000), and
- agnostics and atheists (Winzelberg & Humphreys, 1999; Weiss, Griffin, Gallop, Onken, Gastfriend, Daley, Crits-Christoph, Bishop, & Barber, 2000).

For those seeking support from recovery mutual aid groups, there is a dose effect related to meeting participation. The probability of stable remission rises in tandem with the number of meetings attended in the first three years of recovery (Hoffmann, Harrison, & Belille, 1983; Pisani, Fawcett, Clark, & McGuire, 1993; Humphreys, Moos, & Cohen, 1997; Chappel, 1993). Recovery prospects also rise with the intensity of mutual aid involvement, as measured by active application of program concepts, meeting participation (speaking, interacting, leading), participation in pre- and post-meeting rituals, use of mutual aid networks for fellowship and leisure, reading program literature, being sponsored, sponsoring others, and involvement in other service work (Sheeren, 1988; Cross, Morgan, Moonye, Martin, & Rafter, 1990; Johnson & Herringer, 1993; Emrick et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, & Cohen, 1997). This intensity of participation effect also applies to adolescents (Margolis, Kilpatrick, & Mooney, 2000).

Peer-assisted recovery is also reflected in the growing recovery home movement (most visibly in the Oxford Houses) (Jason, Davis, Ferrari, & Bishop, 2001) and the rapid growth of non-clinical, peer-based recovery support services (White, 2004c).

Natural recovery, treatment-assisted recovery, and peer-assisted styles of recovery are not mutually exclusive. A.A.'s 2004 membership survey reveals that 64% of A.A. members received some type of treatment or counseling prior to joining A.A. and that 65% received professional treatment or counseling after they entered A.A. (Alcoholics Anonymous, 2005). In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to" alcohol and other drugs, 25% reported initiating and sustaining recovery without treatment or mutual aid (Faces & Voices of Recovery, 2001).

## RECOVERY INITIATION FRAMEWORKS (RELIGIOUS, SPIRITUAL, SECULAR)

There are considerable differences in recovery styles based on the presence or absence of religion or spirituality as an important dimension of the recovery process. There are *religious frameworks of recovery* (sometimes referred to as *faith-based*) in which severe alcohol and other drug problems are resolved within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship, and support of a community of shared faith. Within various religious traditions, the abandonment of addiction is viewed as a byproduct of the experience of religious conversion/affiliation and the reconstruction of a faith-based personal identity and lifestyle. In this framework, recovery is a divine gift of grace rather than something that one does. Religion is viewed, not as an enriching dimension of recovery, but as the catalytic agent that initiates and sustains recovery (White & Whiters, 2005). Religious pathways of recovery are marked by:

- a religious rationale for the roots of addiction (e.g., the Islamic interpretation of alcoholism as a fruit of the tree of *Jahiliyyah* (ignorance/idolatry) (Badri, 1976);
- a mytho-magical personification and demonization of drugs and the addiction process, e.g., the Islamic interpretation of drink and drunkenness as an "infamy of Satan's handiwork" (Badri, 1976, pp. 3-5);
- a religious rationale for restraint and temperance (e.g., the body as the temple of God) (Bible, 1 Cr 3:16-17; Miller, 1995);

- rituals of confession, restitution, and forgiveness as tools of psychological reconstruction;
- the use of prayer, reading, and service to others (e.g., witnessing) as daily rituals of recovery; and
- enmeshment in a community of faith that meets needs once met within the culture of addiction.

Religious and spiritual frameworks of recovery can closely co-exist. For example, there are societies that help A.A. members who share a particular religious orientation pursue work on A.A.'s Step Eleven: "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." Two of the oldest Eleventh Step groups are the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS). Eleventh Step groups usually serve as adjuncts rather than alternatives to A.A. participation (White, 1998).

Spiritual frameworks of recovery overlap with religious pathways of recovery in the sense that both flow out of the human condition of wounded imperfection (what William James, 1902, referred to as "torn-to-pieces-hood"), involve experiences of connection with resources within and beyond the self, and involve a core set of values (e.g., humility, gratitude, and forgiveness) (Kurtz & Ketcham, 1992). Spiritual frameworks of recovery such as Alcoholics Anonymous focus on defects of character (self-centeredness, selfishness, dishonesty, resentment, anger, preoccupation with power and control) as the root of addiction, and provide a means of reaching both into oneself (e.g., self-inventory, developing the traits of honesty, humility, and tolerance) and outside oneself (reliance on a Higher Power, prayer, confession, acts of restitution, acts of service, participation in a community of shared experience) (Miller & Kurtz, 1994; Green, Fullilove, & Fullilove, 1998). Spirituality as a framework of recovery involves the embrace of paradox (e.g., "sober alcoholic"), gaining a degree of control by admitting one's powerlessness, and becoming whole by accepting one's imperfection (Kurtz, 1999). Spirituality as a medium of recovery is rooted in the understanding that: 1) human beings are born with a vacuum inside themselves that craves to be filled with meaning, 2) we can artificially and temporarily fulfill this need through the medium of drug intoxication, and 3) more authentic and lasting frameworks of meaning can displace the craving for intoxication. Religious and spiritual frameworks can overlap (e.g., religion as a vehicle of spirituality) or exist as distinct experiences (spirituality without religion, religion without spirituality). One of A.A.'s innovations was its emancipation of spirituality from its explicitly religious roots.

*Secular recovery* is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or rituals (prayer). Secular recovery rests on the belief in the ability of each individual to rationally direct his or her own self-change processes. Secular recovery groups view the roots of addiction more in terms of irrational beliefs about oneself and the world and ineffective coping strategies than in terms of biology, morality, character, or sin. Secular frameworks of recovery such as Secular Organization for Sobriety and LifeRing Secular Recovery reinforce the "Big Decision" or "Sobriety Priority" ("not using no matter what") through a variety of cognitive and behavioral self-change techniques. Where spiritual and religious frameworks of recovery involve a transcendence of self, secular frameworks of recovery involve an assertion of self (White & Nicolaus, 2005). Where spiritual frameworks of recovery emphasize wisdom (emphasis on experience, search for meaning, freedom rooted in the acceptance of limitation, self-transcendence by connection to a greater whole, strength flowing from limitation), secular frameworks of recovery emphasize knowledge (emphasis on scientific evidence, an assertion of control, self-mastery through knowledge of self and knowledge of one's

problem, and strength flowing from personal competence).

All three recovery initiation frameworks share what Morgan (1995a) has described as a 1) re-visioning of self, 2) a re-visioning of one's life-context, and 3) a restructuring of life-stance and lifestyle. All three frameworks share a three-part story-style in which people in recovery report "in a general way what we used to be like, what happened, and what we are like now" (Alcoholics Anonymous, 1939, p. 70). And yet listening to these tales of "rescue and renewal" (Morgan, 1995b), one finds critical differences in the instrument of recovery (the grace/gift of having been changed versus personal ownership of that change), different metaphors and rituals used to initiate and sustain recovery, and different views of the role of a community of shared experience in the recovery process.

## RECOVERY INITIATION STYLES

There are three styles of recovery initiation: *quantum change*, conscious *incremental change,* and a less conscious process that sociologists refer to as *drift*.

Quantum change, also referred to as *transformational change*, is distinguished by its vividness (emotional intensity), suddenness (lack of intentionality), positiveness, and permanence of effect (Miller and C'de Baca, 2001). Quantum change can occur as a breakthrough of self-perception or insight (an epiphany) or as a mystical or religious experience. Both experiences produce fundamental alterations in one's perception of self and the world. The liberation from alcohol and other drug problems and related changes flow from these core alterations of identity and values. Quantum change is sometimes experienced as a Damascus-type[3] conversion (religious, spiritual, or secular in nature) that precisely and forever demarks addiction and recovery. Such recovery conversion experiences are rooted in calamity — often referred to as "hitting bottom." Recovery-catalyzing breakthroughs have been described in the research literature as an "existential crisis" (Coleman, 1978), a "naked lunch experience" (Jorquez, 1993), a "rock bottom experience" (Maddux and Desmond, 1980), a "brief developmental window of opportunity" (White, 1996), a "crossroads" (Klingemann, 1991, 1992), an "epistemological shift" (Shaffer and Jones, 1989), and a "radical reorientation" (Frykholm, 1985). Quantum change as a pathway of addiction recovery has a long history and is often the ignition point of historically important abstinence-based healing and religious/cultural revitalization movements (White, 2004b). Quantum change occurs in religious, spiritual, and secular forms. Illustrative of this experience is the report of Samuel Hadley, whose religious conversion at the Water Street Mission in New York City marked the beginning of a lifetime of service to God and other alcoholics.

> *Although up to that moment my soul had been filled with indescribable gloom, I felt the glorious brightness of the noonday sun shine into my heart. I felt I was a free man….From that moment till now I have never wanted a drink of whiskey, and I have never seen money enough to make me take one. I promised God that night that if he would take away the appetite for strong drink, I would work for him all my life. He has done his part, and I have been trying to do mine* (Quoted in James, 1902, p. 203).

While there is a tendency to grant a special quality to these recovery conversion experiences, Bill Wilson cautioned against such glorification.

> *There is a very natural tendency to set apart those experiences or awakenings which happen to be sudden, spectacular*

[3] The reference to Damascus refers to the Biblical account of the transformation of Saul of Tarsus, the orthodox Jew and prosecutor of Christians, into St. Paul, the Christian missionary, on the road from Jerusalem to Damascus.

*or vision-producing….But as I now look back on this tremendous event* [his own transformative change experience]*….it now seems clear that the only special feature was its electric suddenness and the overwhelming and immediate conviction that it carried to me. In all other respects, however, I am sure that my own experience was not different than that received by every AA member who has strenuously practiced our recovery program* (Wilson, 1962).

In contrast to the lightning strike of quantum change, incremental recovery involves a time-encompassing and stage-dependent process of metamorphosis. Researchers have described many stage models of addiction recovery, including:

- Frykholm's (1985) 3-stage model (ambivalence, lengthening periods of abstinence, and emancipation);
- Biernacki's (1986) four-stage model (a resolution to quit either through drift, rational decision, or "rock bottom" experience; a detachment from the physical and social worlds of addiction; managing cravings and impulses and staying clean (abstinent); and becoming ordinary);
- Waldorf's (1983, 1990) six-stage model (going through changes; forming a resolve; cessation experiments; becoming an ex-addict; learning to be "ordinary"; filling the physical, psychological, social, lifestyle void with family work, religion, politics, and mutual aid);
- Brown's (1985) four-stage model (drinking, transition, early recovery, and ongoing recovery);
- Shaffer and Jones' three-stage model (experiencing turning points, active quitting, and relapse prevention);
- Klingemann's (1991) three-stage model (motivation, action, maintenance); and
- Prochaska and colleagues' (1992) six-stage model (precontemplation, contemplation, planning, action, maintenance, and termination).

Stage models suggest that the process of recovery begins before AOD use is moderated or terminated and that, while linear movement through particular stages is possible, the more common experience is a recycling through these stages before permanent recovery is achieved. The repeated sequence that predates recovery stability might be constructed as follows: escalating AOD-related pain (I need to recover), the desire to change (I want to recover), belief in possibility of change (I can recover), commitment (I am going to recover), experiments in abstinence (I am recovering), and movement from sobriety experiments to sobriety identity (I am an ex-addict; I am a recovered/recovering alcoholic/addict; I no longer use or misuse alcohol or other drugs). Stages of change models are very popular among addiction professionals, but have come under attack for the lack of empirical evidence supporting them (Sutton, 2001; West, 2005).

Quantum change and incremental change have been described as two discrete phenomena, but we have listened to recovery stories in our travels that have dimensions of both. For example, we have seen individuals who repeatedly cycled through preparatory stages of recovery (what we have here referred to as recovery priming) but whose point of recovery stabilization was marked by a profound, life-altering quantum change experience.

The third style of recovery initiation is one of *drift* — the gradual cessation/reduction of AOD use and related problems as a matter of circumstance rather than choice. Here the addict simply "goes with the flow," only to find in retrospect that events and circumstances lead away from drugs and the culture in which his or her drug use was nested (see Waldorf, 1983; Biernacki, 1986, 1990; Granfield & Cloud, 1999). Developmental maturation and environmental change can elicit changes in alcohol and other drug use in some individuals in ways that do not follow the conscious, self-engineered styles of change depicted in stages of change models. For example, some studies of female heroin

addicts depict recovery, not as a central goal, but as an inadvertent outcome of severing contact with former drug-using environments and relationships (Gerstein, Judd, & Rovner, 1979). Some individuals drift out of addiction through processes similar to the processes by which they drifted into addiction, including finding an intense alternative pursuit that gives new meaning to one's life (Cloud & Granfield, 2001).

### RECOVERY IDENTITY

Recovery styles also reflect different *recovery identity* patterns — variations in the extent to which AOD problems and the recovery process influence one's identity, and the degree to which one identifies with other people who share this recovery process. There are those with recovery-neutral identities (persons who have resolved severe AOD problems but who do not self-identify as "alcoholics," "addicts," or "persons in recovery"), those with recovery-positive identities (those for whom the status of recovery from addiction has become an important part of their personal identities), and those with recovery-negative identities (those whose addiction/recovery status is self-acknowledged but not shared with others due to a sense of personal shame derived from this status).

These identities, rather than being mutually exclusive, can constitute different points in a prolonged recovery career. For example, we have witnessed such evolution in the modern history of recovering people working as addiction counselors. Early addiction counselors boldly proclaimed their recovery status as their primary credential, but began withholding that recovery status in the 1980s and 1990s behind their accumulating credentials and the restigmatization of AOD problems. In the face of a new recovery advocacy movement calling upon recovering people to put a face and voice on recovery, many of those same addiction counselors are again going public with their recovery status. In our experience, evolution in identity is the norm in addiction recovery.

### RECOVERY RELATIONSHIPS

There are acultural *styles of recovery* in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery and without identification with a larger *recovery community* or *culture of recovery* (a social network of recovering people with their own recovery-based history, language, rituals, symbols, literature, and values). This is not to say that this style of recovery is void of social support, but that support usually comes from one's inner family and social circle rather than from a larger community of recovering people. Gerry Spense, the noted trial lawyer, describes this style of recovery:

> *We (Gerry and his new wife) sort of became each other's A.A. We quit together, and we hung on to each other. Although I have never attended an Alcoholics Anonymous session, we must have had the kind of experience that people have there.* (Quoted in *Wholey, 1984, p. 106.)*

In contrast, there are *bicultural styles of recovery,* in which individuals sustain their recovery through simultaneous involvement in a culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). There are also *enmeshed styles of recovery,* in which one initiates and maintains recovery in almost complete sequestration within a culture of recovery (White, 1996).

These styles are not mutually exclusive and can change over the course of recovery, with some individuals exhibiting very enmeshed styles of early recovery, only to migrate toward a bicultural or acultural style of recovery later in their lives. Some individuals use recovery mutual aid groups for recovery initiation and maintenance, where others seem to initiate recovery through such resources, but then sustain that recovery through their own personal, family, and social resources. Some continue Twelve Step or other recovery maintenance practices without meeting participation,

while others find other sources of long-term recovery support (Tonigan, Miller, Chavez, Porter, Worth, Westphal, Carroll, Repa, Martin, & Tracy, 2002). A relatively recent phenomenon is the advent of *virtual (Internet) recovery* — the achievement or maintenance of recovery through Internet support groups, with little or no participation in face-to-face support meetings. Web-based recovery support services include email and instant messaging systems, newsgroups, bulletin boards, chat rooms, self-assessment instruments, and recovery coaching (Walters, Hester, Chiauzzi, & Miller, 2005). The Internet seems to elicit a much higher degree of participation among women and individuals in high-status occupations than do either professional treatment or face-to-face recovery mutual aid groups (Hall & Tidwell, 2003).

*Communities of recovery* is a phrase coined by Ernest Kurtz to convey the existence of multiple recovery communities. Addiction treatment professionals should refer people to these communities with the goal of achieving reciprocity of fit between the individual and the group. Style differences based on the evolution in how one relates (or does not relate) to these communities of recovery are part of what could be described as one's *recovery career*. The concept of *career* has been applied to the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Timko, Moos, Finney, Moos, & Kaplowitz, 1999; Dennis, Scott, Funk, & Foss, 2005). *Recovery career* is an extension of this application and refers to the evolving stages of recovery stability and one's identity and recovery support relationships over time.

### VARIETIES OF TWELVE-STEP EXPERIENCE

Peer-based support groups constitute a major resource for the resolution of alcohol and other drug problems (Room & Greenfield, 1993; Kessler, Mickelson, & Zhoa, 1997; Kissin, McLeod, & McKay, 2003). Such groups are attractive, are geographically accessible and affordable, require no formal admission procedures, and place no limits on length of participation (Humphreys, et al., 2004). Twelve-Step groups began with the founding of Alcoholics Anonymous in 1935. Although there were dozens of recovery mutual aid societies that pre-dated A.A. (White, 2001), A.A. continues to be the standard by which other mutual aid groups are measured due to its size (2.1 million members in 100,766 groups), geographical growth (150 countries), and longevity (Kurtz & White, 2003). Varieties of A.A. experience were evident from its inception (e.g., differences between A.A. in Akron and New York City) and have grown throughout A.A.'s history.

Varieties of A.A. experience are reflected in the diversity of A.A. meeting formats (e.g., open vs. closed meetings, speaker meetings vs. discussion meetings), in the trend to organize A.A. around special populations and special needs, and in the wide variance of styles of "working" the A.A. program. Local A.A. meeting lists reflect such specialization, e.g., meetings organized by age (young people's meetings, old-timers meetings), gender (women-only and men-only meetings), sexual orientation (lesbian, gay, bisexual, transgender), language (Spanish, Polish, no profanity), profession (physicians, lawyers, airline pilots), social status (off-the-books meetings for celebrities and those in high-status positions), relationship status (single, couples), co-occurring problems (psychiatric illness, HIV/AIDS), and smoking status (non-smoking), to name just a few. There are differences in A.A. that transcend filtering the A.A. program through particular types of categorical/cultural experience. Significant differences can be found in A.A. meetings related to such factors as degree of religious orientation (from efforts to Christianize A.A. to A.A. groups for atheists and agnostics), meeting rituals, pre- and post meeting activities; and basic interpretations of the nature of the A.A. program (Kurtz & White, 2003). Such varieties multiply exponentially when one examines the range of adaptations of A.A.'s Twelve Steps to other drug problems (e.g., Narcotics Anonymous, Cocaine Anonymous, Marijuana

Anonymous, Pills Anonymous, Methadone Anonymous) and to co-occurring problems (e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery).

The explosive growth of A.A. in the 1970s and 1980s and the growing influence of the addiction treatment industry and the criminal justice system upon A.A. (via mandated A.A. attendance) led to concerns among A.A. old-timers that the core of A.A.'s program was being corrupted. This concern led to efforts to define and recapture the historical A.A. A.A. historian Ernest Kurtz (1999, pp. 131-138) proposed five criteria to distinguish "real A.A." from meetings that had taken on the flavor of treatment groups: 1) A.A. vocabulary (defects of character, self-inventory, Higher Power) rather than treatment vocabulary; 2) humor and the appreciation of paradox; 3) a story style that "describes in a general way what we used to be like, what happened, and what we are like now"; 4) respect for and adherence to A.A. traditions; and 5) a conviction by those attending meetings that they NEED rather than WANT to be there.

The growing varieties of A.A. experience triggered efforts in the scientific community to define the "active ingredients" of A.A. These scientists, confronted with the large menu of concepts and activities that make up the A.A. experience, attempted to define which aspects of the A.A. experience were the most potent in altering the course of alcoholism and strengthening the recovery experience. To-date, these studies have focused on such mechanisms as motivational enhancement, development of Twelve-Step cognitions (e.g., commitment to abstinence and continued A.A. participation), recovery coaching (advice), mastery of behavioral prescriptions for coping, exposure to recovery role models, enhanced self-efficacy, changes in friendship networks, and the therapeutic benefits of helping others (Morgenstern, et al., 1997; Humphreys, Mankowski, Moos, & Finney, 1999; Pagano, Friend, Tonigan, & Stout, 2004). Scientists have also plotted a continuum of response to Twelve-Step involvement across three populations: optimal responders, nonresponders, and partial responders (Morgenstern, Kahler, Frey, & Labouvie, 1996).

Other areas of diverse experience within Twelve-Step groups include patterns of co-attendance of Twelve Step and other groups, e.g., attending A.A. and Al-Anon, A.A. and N.A., A.A. and Women for Sobriety; patterns of primary affiliation (e.g., shifting primary allegiance from N.A. to A.A.); patterns of intensity of participation (frequency of meeting attendance and other Twelve-Step practices); and duration of participation over time (e.g., decreasing involvement or disengagement from regular involvement in meetings and rituals).

### STILL OTHER VARIETIES

The existence of those who did not respond or only partially responded to spiritually oriented Twelve-Step programs set the stage for the emergence of explicitly religious and secular frameworks of peer-based recovery support (Humphreys, 2004). Religious recovery support groups include (with their founding dates where available) Alcoholics Victorious (1948), Teen Challenge (1961), Alcoholics for Christ (1976), Overcomers Outreach (1977), Liontamers Anonymous (1980), Mountain Movers, High Ground, Free N' One, Victorious Lady, Celebrate Recovery, Millati Islami, and innumerable local recovery-support ministries. As noted earlier, these groups share a religious interpretation of the roots of addiction (e.g., as a sin of the flesh, idolatry, or demonic possession), recovery founded on total surrender to a religious deity, a religiously based reconstruction of personal identity and values, and immersion in a faith-based community (White & Whiters, 2005).

Secular recovery support groups (with their founding dates) include Women for Sobriety (WFS) (1975), Secular Sobriety Groups (later renamed Secular Organization for Sobriety — Save Our Selves (SOS) (1985), Rational Recovery (RR) (1986), Men for Sobriety (MFS) (1988), Moderation Management (MM) (1994), SMART Recovery® (1994), and LifeRing Secular Recovery (LSR) (1999). Secular groups are

distinguished by their meeting locations (homes and religiously neutral sites); lack of reference to religious deities; discouragement of self-labeling ("alcoholic" and "addict"); emphasis on personal empowerment and self-reliance; openness to crosstalk (direct feedback and advice between members); lack of formal sponsorship; encouragement to complete a recovery process and move on to a full, meaningful life (rather than sustain meeting participation for life); and use of volunteer professional advisors (persons not in personal recovery) to facilitate and speak at meetings (White & Nicolaus, 2005).

Individuals who participate in Twelve-Step alternatives may do so exclusively, concurrently with A.A. meetings, or sequentially (using one framework to initiate recovery and another framework to maintain and enrich that recovery over time (Kaskutas, 1992; Connors, Dermen & Duerr, 1992; White & Nicolaus, 2005).

## RECOVERY DURABILITY

Interest has grown over the past decade in the prospects and processes involved in long-term recovery stabilization (Morgan, 1995; Chappel, 1993), as it has become clear that short periods of sobriety or decelerated AOD use are not predictive of sustained recovery. Some researchers have claimed that stable remission can be predicted by as little as six months of sobriety (Armor, Polich, & Stambul, 1978). Vaillant (1983), in a prospective study of alcoholic men, found that the stability and durability of addiction recovery increases with length of sobriety, with no relapses in his study among those who had achieved six or more years of continuous sobriety. A growing number of studies are suggesting that the point at which most recoveries from alcohol dependence become fully stabilized is between four and five years of continuous remission (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, O'Donnel, & De Soto, 1989; Dawson, 1996; Jin, Rourke, Patterson, Taylor & Grant, 1998). Once attained, recovery from alcohol dependence is more stable for those with late-onset alcohol problems compared to those with early-onset alcohol problems (Schutte, Brennan & Moos, 1994).

Studies of heroin addicts further confirm the fragility of short periods of abstinence. Follow-up studies have demonstrated that only 42% percent of those abstaining from opiates in the community at two-year follow-up were still abstinent at five-year follow-up (Duvall, Lock, & Brill, 1963). One third of those who achieve three years of abstinence eventually relapse (Maddux & Desmond, 1981), and one quarter of heroin addicts with five or more years of abstinence later return to heroin use (Hser, Hoffman, Grella, & Anglin, 2001).

While recovery stability seems to vary somewhat across drugs used, the principle that recovery becomes more stable over time seems to apply to all patterns of addiction. In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to alcohol or other drugs," half reported being in stable recovery more than five years, and 34% reported having achieved stable recovery lasting ten or more years (Faces & Voices of Recovery, 2001). The average length of continuous sobriety reported in the latest membership survey of Alcoholics Anonymous was 8 years, with 36% of A.A. members reporting continuous sobriety of more than 10 years (*A.A. Grapevine*, July, 2005).

Persons who achieve full, uninterrupted recovery for five years, like persons who have achieved similar patterns of symptom remission from other primary health disorders, can be described as *recovered*. In general, this means that the risk of future lifetime relapse has approached the level of addiction risk for persons without a history of prior addiction. Those who achieve full symptom remission for less than five years or who have achieved partial recovery (marked reduction of AOD use and related consequences) can best be described as *in recovery* or *recovering*. Use of the term *recovering* in later years (after five years) of recovery reminds the individual that recovery is an enduring process requiring sustained vigilance and recovery maintenance. However, such use, by

inadvertently conveying the lack of a permanent solution for severe AOD problems, may contribute to the stigma and pessimism attached to these problems.

### RECOVERY TERMINATION

One of the recent controversies related to recovery from addiction involves the question of whether addiction recovery is ever fully completed. The stage models of recovery summarized earlier collectively portray four broad stages of recovery: 1) *recovery priming* (experiences that open a doorway of entry into recovery), 2) *recovery initiation* (discovering a workable strategy of problem stabilization), 3) *recovery maintenance* (achieving recovery stability and sustaining and refining broader strategies of problem resolution with a continued focus on the recovery process), and 4) *recovery termination* (achievement of global health with diminished preoccupation with recovery). This last stage, referred to as *Stage II Recovery* ("rebuilding the life that was saved in Stage I") (Larsen, 1985, p. 15), transcends the early concern with the addictive behavior and focuses on a reconstruction of personal character, identity, beliefs, and interpersonal relationships. This stage is also referred to as *completed recovery* or the *real thirteenth step*[4] — an "advanced state" of recovery marked by global health and a heightened capacity for intimacy, serenity, self-acceptance, and public service (Picucci, 2002; Tessina, 1991).

### IMPLICATIONS FOR THE PROFESSIONAL TREATMENT OF AOD PROBLEMS

This review contains critical understandings that could help shape recovery-oriented systems of care. Some of the most important of these include the following.

**Paradigmatic Shift:** There will be increasing calls to shift addiction treatment and addiction counseling from a problem-focused or intervention-focused paradigm to a recovery paradigm. This will shift the emphasis of treatment from one of brief biopsychoscial stabilization to one of sustained recovery management (pre-recovery engagement; recovery initiation; sustained monitoring; stage-appropriate recovery education and coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention) (White, Boyle & Loveland, 2003).

**Recovery Definition and Scope:** The shift to a recovery paradigm will require considerable discussion between the professional addictions field and diverse communities of recovery about the very definition of recovery. These discussions will be contentious, but we would make the following predictions:

1. Abstinence will shift from its status as a *goal* and definitional requirement of recovery to the status of *one method* of achieving recovery (and the preferred method for those with the most severe AOD problems). The goal will shift to the resolution of AOD problems by any means possible — a goal that will legitimize moderated outcomes for those with less severe AOD problems.

2. The focal point of recovery (changes in one's primary drug relationship) will broaden to include a healthy relationship or non-relationship with all psychoactive drugs and the achievement of global health. Addiction treatment programs will increasingly be held accountable for multiple recovery outcomes, e.g., changes in primary and secondary drug use as well as changes in physical, emotional, family/relational, and occupational/academic health and functioning. There will be a shift in focus from what recovery

[4] The thirteenth step is a euphemism for romantic involvement between AA members and, more specifically, the sexual overture by an older AA member to a newly sobered AA member.

eliminates (AOD use and related problems) to what recovery adds to individuals, families, and communities (global health, occupational and academic productivity, active citizenship) (http://www.samhsa.gov/Matrix/SAP_treatment.aspx).

3. Re-elevating the concept of *family recovery* will exert pressure for new technologies of family assessment, intervention, and sustained monitoring as well as impetus for a family-oriented recovery research agenda.

4. The concept of *partial recovery* will receive greater elucidation and legitimacy within the addictions treatment field, and cases of *enriched recovery* (dramatically elevated health, functioning, and community service) will be documented and culturally elevated to help ameliorate the social stigma that continues to be attached to AOD problems.

**Recovery Capital:** The pathology and intervention paradigms that have guided addiction treatment have shaped assessment and placement protocol so that they focus almost exclusively on problem severity and complexity. The resiliency/recovery paradigm calls for measuring recovery capital; distinguishing the role of recovery capital in *natural*, *treatment-assisted*, and *peer-assisted* recoveries; and giving prominence to an individual's/family's recovery capital within the process of clinical decision-making. The most important implication of the concept of recovery capital is the premise that not all individuals experiencing AOD problems need professional treatment. Individuals with lower problem severity and high recovery capital can be encouraged to explore natural and peer-based resources as less restrictive, less expensive, and less stigma-laden alternatives to addiction treatment. Monitoring responses to such resources can be used to determine if and when professional services are necessary.

**Medication-Assisted Recovery:** Tension is growing between an anti-medication bias within the field of addiction treatment (and within American communities of recovery and the larger American culture), the growing availability of a wide variety of pharmacological adjuncts in the treatment of addiction, and the growth in scientific evidence supporting their effectiveness. We anticipate a day when the legitimacy of such pharmacological adjuncts will be widely recognized in professional and recovery communities and integrated within the large spectrum of treatment and recovery support services. If such legitimacy is not achieved, we would anticipate a schism within the field in which more scientifically and medically based treatments split off into a separate field within primary medicine. We would consider this further splitting of body from mind and soul a tragic event in the history of the field.

**Recovery Frameworks:** Religious, spiritual, and secular frameworks of recovery must be more completely charted and evaluated, with a particular focus on their applicability to particular cultural and clinical populations. For example, researchers have extensively studied (some would say over-studied) AOD problems in Native American and African American communities, but no comparable quantity of literature exists on the varieties of recovery experience within these communities. How many African Americans initiate and sustain recovery through the historical Black church? How many African Americans initiate recovery through A.A. or N.A. and then migrate into the Black church to sustain their recoveries? How many Native Americans use indigenous cultural or religious revitalization movements as a framework for long-term sobriety? In the same vein, how do members of secular frameworks of recovery differ from those in religious or Twelve-Step frameworks of recovery? What mechanisms of change are shared across religious, spiritual, and secular frameworks of recovery; and what

mechanisms of change distinguish such frameworks from each other? Definitive, scientifically researched answers to such questions do not yet exist.

**Recovery Styles:** Variations in how recovery is initiated and how recovery shapes personal identity and interpersonal relationships illustrate the diversity of experiences that constitute recovery from AOD problems. Further documentation of such styles and their relative prevalence across cultural and clinical subpopulations is needed to guide the delivery of treatment and recovery support services. The elucidation of recovery styles is part of a larger recovery research agenda that is currently gaining prominence.

**Varieties of Recovery Mutual Support Societies:** The numerical expansion and growing diversity of peer-based recovery support groups suggests the need for all addictions professionals to become students of such groups, develop relationships with these groups, provide clients information about such groups, and develop a style of active linkage to these groups. The diversity of recovery support groups has prompted calls for matching individual clients to particular groups by such factors as age, gender, socioeconomic status, drug of choice, smoking status, and attitudes toward religion and spirituality (Forman, 2002; White & Nicolaus, 2005). Celebration of the growing diversity of recovery pathways and a philosophy of choice permeate the philosophies of the best treatment programs. Recent reviews of treatment effectiveness have linked this philosophy of choice to enhanced motivation and treatment outcomes (Hester & Miller, 2003). All recovery support structures, like all treatments, will have optimal responders, partial responders, and non-responders. This calls for continued monitoring and support to get the best possible fit between each individual and a particular method of treatment or recovery support. Combinations of natural resources, peer recovery networks, and professional treatment may generate amplified recovery outcomes for those individuals and families with the greatest problem severity and complexity.

## SUMMARY AND CONCLUSIONS

The extension of the pathology and intervention paradigms toward a recovery paradigm will generate significant new understandings about the varieties of recovery experience. However, our understanding of those varieties is in its infancy. It is time the recognition of multiple pathways and styles of recovery moved beyond the level of superficial rhetoric. It is time the field aggressively pursued a recovery research agenda. It is time that the recognition of multiple pathways and styles of recovery fully permeated the philosophies and clinical protocols of all organizations providing addiction treatment and recovery support services.

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## Adolescent Recovery: What We Need to Know

## A Commentary

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Student assistance professionals have long been on the front lines of responding to alcohol and other drug (AOD) problems among young people but have lacked service models derived specifically from studies of the long-term solutions to these problems. As a country, we have a commanding knowledge of the pharmacology of psychoactive drugs, adolescent drug use trends, and the factors that contribute to youthful drug experimentation. We know a great deal about the etiology, patterns, course, and consequences of adolescent substance use disorders, and we are beginning to build an impressive body of knowledge from studies evaluating prevention, early intervention, and treatment programs. Studies of AOD problems and interventions to resolve them have advanced our responses to these problems, but there are growing calls for extending the existing research agenda to embrace a resilience and recovery paradigm (White, 2005).

The resilience and recovery paradigm posits that solutions to AOD problems already exist in the lives of individuals, families, neighborhoods, and communities and that our focus of study should be extended to learn from these successes. The assumption is that studying "at-risk" individuals who have resisted development of AOD problems or who have experienced but then resolved these problems will reveal principles and practices that can lead to more effective prevention and treatment strategies. This article hopes to spark interest in this emerging paradigm by posing questions about the resolution of severe AOD problems among adolescents that have received limited scientific inquiry. These missing links stand as potential catalysts for system transformation in the prevention and treatment arenas.

### Defining Recovery

A factor inhibiting adolescent recovery research is the lack of scientific consensus on a definition of recovery. There is general agreement among adolescents who have resolved AOD problems and those who have assisted in that process that recovery is more than the removal or radical

deceleration of alcohol and drug use from an otherwise unchanged life. Adolescent alcohol and other drug problems are often closely bundled with other personal or family problems. Recovery connotes the broader resolution of these problems and the movement toward greater physical, emotional, and relational health. Recovery also frequently involves improved educational and vocational performance, the formulation of and movement toward life goals, and acts of service to the community. We need a recovery definition that is marked by precision (offers clarity and measurability), inclusiveness (embraces varieties of AOD resolution pathways and styles), and exclusiveness (withholds recovery status from those lacking essential recovery ingredients, e.g., those who shift from alcohol dependence to cannabis dependence) (White, in press). Achieving such a consensus definition is a considerable challenge that must be met.

**Degrees of Recovery**

White and Kurtz (2006) have described three depths of recovery based on the degree of change involved in the recovery process. These include full recovery (complete resolution of AOD problems and movement towards global health), partial recovery (reduced frequency, intensity, and consequences of AOD use and related problems), and transcendent recovery (full recovery followed by an extraordinary level of personal achievement and social contribution). What is the point-in-time prevalence of these different patterns of recovery among young people? What is the course of these patterns over time? Is partial recovery a permanent state or a precursor to re-addiction or full recovery? What factors predict depth of recovery? Are there particular types of services associated with the movement from partial to full recovery?

**Recovery Prevalence**

We know from clinical follow-up and community surveys of adults that recovery rates for substance use disorders approach or exceed 50% across all ages (Dawson, et al., 2005; Vaillant, 2003), but we have no comparable studies that isolate long-term recovery rates for adolescents. We meticulously and repeatedly measure the incidence and prevalence of adolescent AOD use as well as changes in perceptions and attitudes toward such use, but we do not know the prevalence of adolescent recovery. Is the prevalence of recovery among young people increasing or decreasing in your school, in your community, and in the country as a whole? Do adolescent recovery rates differ by gender, ethnicity, drug choice, or other important variables? We need long-term National Institutes of Health studies that track the course of adolescent AOD problems and their resolution patterns into adulthood to help us answer such questions.

**Age of Onset**

We know that lowered age of onset of regular alcohol and other drug use increases risk for the development of AOD problems and is linked to more severe AOD problems and related behaviors (White, Godley, & Dennis, 2003). We do not know how age of onset of regular AOD use affects later recovery prospects and processes. Nor do we know how age of onset of recovery influences styles and stages of recovery, or whether there are particular windows of opportunity for recovery initiation that, if not capitalized upon early, will not open again until a much later point in one's addiction career.

**Recovery Effects on Risk**

We know that a family history of AOD-related problems increases an adolescent's risks for developing such problems, but we do not have answers to questions like the following. Does a family history of recovery ameliorate the risk for AOD problems in the generations that follow? Does the recovery of an adolescent affect the problem vulnerability or course of such problems among his or her siblings? Does recovery of a young person affect the recovery prognosis of siblings who subsequently

develop such problems? Answers to such questions could have great import to prevention, early intervention, and treatment strategies.

**"Recovery Capital"**

Nearly every adolescent screening and assessment instrument generates recommendations related to service needs based on an evaluation of problem severity data. Only a few of these instruments illuminate how a level of service intensity could be similarly influenced by *recovery capital*—a concept reflected in the recent emphasis on "strengths-based" approaches. Recovery capital is the total quantity of internal and external assets that an adolescent can draw upon to resolve AOD problems (Granfield & Cloud, 1999). Those of us who have had extensive contact with adolescents and young adults know individuals who develop transient AOD problems and then go on to resolve these problems without involvement in professional treatment or recovery support groups. The answer to why some youth mature out of AOD problems while others spiral into chronic drug dependence may well lie within this dimension of recovery capital. We need to know more about how problem severity and recovery capital interact to shape the course and outcomes of adolescent substance use disorders.

**Pathways and Styles of Recovery**

There is growing interest in the religious, spiritual, and secular frameworks that aid recovery initiation and how these frameworks can evolve throughout the years of recovery maintenance. There is similar interest in the diversity of ways people achieve recovery (e.g., natural recovery, treatment-assisted, peer-assisted) and the changes in personal identity and interpersonal relationships throughout the recovery process (White & Kurtz, 2006). Little of this work has examined recovery across the life cycle or examined how recovery initiation and maintenance differs for adolescents and adults.

We know more about the adolescent treatment process than we know about the processes involved in long-term adolescent recovery. Knowledge of recovery could well serve as a foundation for dramatic enhancements in the quality and effectiveness of adolescent treatment. The goal is to move adolescent treatment from serial episodes of acute biopsychosocial stabilization to a process of sustained recovery support. That shift in focus could be guided by a new science of addiction recovery.

**The Stages of Adolescent Recovery**

There are anecdotal reports of youth with severe substance use problems who experience a profound breakthrough of self-perception that suddenly and permanently alters their prior pattern of substance use. Yet recent studies of transformational change experiences have focused exclusively on adults (Miller & C'de Baca, 2001). A pattern of recovery more commonly seen by student assistance and treatment professionals occurs when young people move through substance use problems toward the achievement of stable recovery in incremental steps. The Transtheoretical (Stages of Change) Model (Prochaska, Norcross, & DiClemente, 1994) has been a popular framework to explain how people who are drug dependent move from problem denial/minimization through increased awareness to problem resolution and solution maintenance, but this model is being scientifically challenged (West, 2005) and has not been tested in well-designed studies for its applicability to the adolescent recovery process. We need to map the course of long-term adolescent recovery and the support strategies that are most helpful at particular stages in this process.

**Recovery and Family Environment**

There are numerous studies on the effects of family environment on the development of AOD problems in adolescents, but we know very little about how the family environment and longer-term

family relationships influence the course of long-term recovery. Godley and colleagues (Godley, Kahn, Dennis, Godley, & Funk, 2005) provide an example of a study that uses data over a 12-month follow-up period to examine the relationship of recovery environment (including family measures) and social risk (including peer measures) to outcomes. Important questions in this area are: Do adolescents who are enmeshed in heavy AOD-using family subcultures need to completely sever family ties to sustain their recoveries? To what extent do recovery support groups serve as surrogate family structures for recovering adolescents? We do not have complete answers to the most important question of all: How can parents and other family members best help a young person initiate and sustain his or her recovery over a lifetime?

**Treatment and Recovery**

The picture we have of the treatment of adolescent substance use disorders is a complicated one. On the one hand, treatment outcome studies consistently confirm potential positive effects of treatment of varied modalities and theoretical orientations—including Twelve Step approaches, cognitive-behavioral therapies, family-based approaches, and therapeutic communities. On the other hand, no one adolescent treatment approach has been found to be consistently superior to the others. Studies across these approaches confirm low rates of voluntary attraction to treatment, low rates of sustained sobriety following treatment, and high treatment re-admission rates. What is left unanswered in all of this, based on the short follow-up windows of existing studies, is the relationship between adolescent treatment and the prospects of long-term recovery.

We need replicated studies that answer such questions as: 1) Does treatment of a substance use disorder in adolescence increase the prospects of long-term recovery even if that recovery is not immediate? 2) Does an earlier stage of treatment initiation (measured by age and the time from first problem development to treatment entry) shorten addiction and treatment careers? 3) What are the effects of post-treatment monitoring, recovery coaching, assertive linkage to communities of recovery, and early re-intervention on long-term recovery outcomes for adolescents? 4) What effects do efforts to shape the post-treatment family and social environment have on long-term recovery outcomes? We have already learned that treatment-imposed respites in addiction careers do not in themselves constitute sustainable recovery. We need to know the specific treatment and post-treatment recovery support services delivered at age 15 that predict recovery status at age 25, 35, and older. We need a research-guided bridge between treatment and long-term recovery.

**Role of Recovery Support Groups**

Most everything we know about groups like Alcoholics Anonymous, Narcotics Anonymous, other Twelve Step groups, and their religious and secular alternatives is based on studies of adult members of these groups. While John Kelly, Mark Myers, Sandra Brown (2000), and others have begun to chart the patterns of adolescent involvement in these groups and their effects on short- and long-term recovery rates, research in this area remains in its infancy. We need studies with replicated findings across geographical and cultural contexts and across key demographic, personality, and problem severity variables that illuminate adolescent recovery support group affiliation rates, obstacles to participation, the differential effects of mainstream versus young people's meetings, the active ingredients of participation most linked to long-term recovery outcomes, and any negative side-effects resulting from such participation. There is a growing pool of young people in long-term recovery within these support groups. They have much to teach us.

## Peer-based Recovery Support Services

There is growing interest in the role of peer-based recovery support services provided by volunteer or paid specialists (recovery coaches, personal recovery assistants) and delivered through local treatment agencies, recovery advocacy and support organizations, or faith-based recovery ministries. The Center for Substance Abuse Treatment's Recovery Community Support Program is designed specifically to fund and support such projects. The emerging models for delivering peer-based recovery support services are based exclusively on adult populations and have yet to be rigorously evaluated. There is a need to pilot school-based and community-based peer-based recovery support services for adolescents and evaluate the effects of such services on long-term recovery rates and processes.

## Wired Recovery

There are two technologies that are currently at the core of adolescent culture in the United States that also constitute underutilized mechanisms of post-treatment recovery support: the cell phone and the Internet. Recent research is holding out great promise for telephone-based continuing care following treatment (Kaminer & Napolitano, 2004), and there are growing numbers of people who are using Online support groups as alternatives or adjuncts to traditional face-to-face recovery support meetings (Hall & Tidwell, 2003; White & Kurtz, 2006). There is enormous potential in these technologies to enhance long-term recovery outcomes, just as there are potentially harmful side-effects of such technologies. We need research studies that map these potentials and pitfalls.

## Recovery and School Performance

Many studies have noted the detrimental effects of AOD-involvement on school performance, but we know very little about how recovery affects such performance or if there are special recovery support services that are specifically linked to increased school performance. We need to identify the extent to which innovations such as recovery schools, SAP-sponsored recovery support groups, school-based peer mentor programs, and other school-based recovery support services enhance academic performance and graduation rates (White & Finch, 2006).

## Toward a Recovery Research Agenda

As a country, we have focused attention on adolescent AOD problems for more than 200 years and have admitted and studied adolescents within American treatment institutions since the 1860s. We know a lot about the pathology of addiction and the mechanics of intervention. It is time we studied the lived solutions to AOD problems among young people and their families and the lessons these solutions hold for the redesign of community-based treatment and school-based recovery support services. We invite student assistance professionals and others concerned about substance-involved youth to join us in advocating for this revolution in perspective.

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# Selected Papers of William L. White

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## Chronic Addiction and Recovery Management: Implications for Clinical Practice

**Christy Scott, Ph.D., William White, MA, and Michael L. Dennis, Ph.D.**
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In 2001, Dr. Lonnie Shavelson published *Hooked*, a provocative study of the lives of five individuals whose addictions propelled them through multiple episodes of addiction treatment and encounters with a host of other community institutions. Shavelson's ethnography of addiction was in part an exposé of a treatment system that failed to comprehend and respond to the chronic and complex nature of addiction and recovery. This article summarizes the empirical evidence that addiction is for many a chronic condition, identifies risk factors for such chronicity, highlights the consequences of treating chronic addiction in the context of an acute care model, and notes the emergence of sustained recovery management models as well as the clinical implications of such models.

### Addiction: Acute or Chronic Condition?

Community surveys reveal high lifetime consumption of alcohol and other drugs in the general population and the existence of substantial numbers of people with transient AOD-related problems who resolve these problems without the aid of professional treatment or recovery support groups. Clinical studies, however, reveal people with more severe and chronic conditions who are unlikely to recover without such assistance and support. There is growing evidence that many individuals in this latter group experience prolonged cycles of addiction, recovery, relapse, and repeated treatments before achieving stable recovery or experiencing permanent disability or death (Anglin et al., 1997; Dennis, Scott et al., 2005; Scott, Foss et al., 2005b). The evidence of chronicity among the population admitted to publicly funded addiction treatment is striking.

Most people entering publicly funded addiction treatment in the United States have prolonged histories (measured in years and decades) of AOD problems prior to their first admission to treatment (Dennis et al., 2005).

- While the majority of people with lifetime substance dependence eventually enter sustained recovery (i.e., no symptoms for the past year) (Dawson, et al., 2005), most do so after participating in multiple episodes of treatment. Dennis, Scott, and colleagues (2005) recently found that

the median time from first use to a year of abstinence was 27 years; the median time from first treatment to a year of abstinence was 9 years, which included 3 to 4 episodes of treatment.

- Of the people admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment (including 23% for the second time, 22% 3-4 times, and 19% 5 or more times) (OAS, 2005).
- The majority of individuals discharged from addiction treatment will relapse within 3 to 12 months after discharge, most within 30-90 days (Wilbourne & Miller, 2003; Hubbard, Flynn, Craddock, & Fletcher, 2001; Scott et al., 2005b). Instability of recovery continues throughout the early years of recovery (Scott et al., 2005a).
- Post-treatment recovery outcomes are compromised by the low rate of participation in continuing care activities following discharge and the substantial drop-out rate of recovery support group participation in the year following treatment (McKay, 2001).

Findings such as these have prompted leading researchers to speak of addiction and treatment "careers" (Anglin et al., 1997) call for the reconceptualization of addiction as a chronic disorder on par with cancer, diabetes, asthma, and hypertension (McLellan et al., 2000; Scott & Dennis, 2006; Dennis & Scott, in press), and advocate a shift to models of sustained recovery management similar to those used in the treatment of other chronic diseases (White et al., 2002).

## Factors Contributing to the Chronicity

Prolonged complex service histories are especially prevalent when addiction is accompanied by medical, psychiatric, and other problems—a significant finding given the high rate of co-occurring disorders among those entering addiction treatment. Relative to people with lower severity, those who have more chronic substance use disorders are characterized by:

- Greater personal vulnerability (e.g., family history of AOD problems, early age of onset of AOD use/problems, developmental trauma),
- Greater problem severity (e.g., amount of use, number of abuse/ dependence symptoms),
- Greater problem complexity (e.g., co-occurring medical/psychiatric illness, personal and environmental obstacles to recovery, enmeshment in a culture of addiction), and
- Lower recovery capital (e.g., fewer internal and external assets that can be used to initiate and sustain recovery) (White et al., 2002).

## Chronic Conditions and Acute Models of Care

Historically, most health care systems, including substance abuse treatment, have been organized around an episodic relationship in which a person seeks help, is diagnosed and treated, and is discharged and presumed to be cured—all in a relatively short period of time. In the addictions field, policy makers, funders, clinicians, patients and their families, and the public often have the unrealistic expectation that all patients entering addiction treatment should achieve and maintain lifelong abstinence following a single, ever-briefer episode of specialized treatment. The earlier noted post-treatment relapse rates invalidate this assumption and challenge the adequacy of an acute care model of treatment for individuals suffering from chronic substance use disorders. Unlike conditions or illnesses that are time-limited and treatable in single episodes of acute care, chronic conditions ebb and flow over long periods of time, and their course is not

fundamentally altered by acute episodes of stabilization.

Treating chronic conditions in the context of an acute care model can harm service consumers, service professionals, and service organizations. Clients become demoralized, give up on themselves, and may give up on professional treatment. Family members, friends, employers, judges, probation officers, child welfare workers, professional licensing boards, and others become frustrated by frequent relapse and attribute relapses to willful recalcitrance. Unrealistic expectations of treatment often result in clients being punished for their inability to establish instant and permanent sobriety. Facing repeated relapse, clinical staff can also become demoralized and avoid confronting the client's or their own self-perceived "failures" by refusing to re-admit the client or shaming the client at re-admission. If addiction treatment is evaluated based on the short-term expectations of the acute care model, then everyone, including the public and policy makers, risks disillusionment regarding the effectiveness of addiction treatment.

It is our contention that treatment "works" but not in the way many have presumed it should (i.e., that a single episode of care is a self-contained fix for severe AOD problems) and that it could "work" better if the treatment model better matched the growing understanding of the condition. In the next section, we briefly review some of the more recent attempts to shift treatment toward a model of long-term recovery management.

## From Acute Care to Sustained Recovery Management

The shift from acute models of addiction treatment to models of long term recovery management requires changes in service philosophies, significant shifts in service practices, and a transformation in the way addiction treatment and recovery support services are planned, funded, monitored, and evaluated. In states (e.g., Connecticut), cities (e.g., Philadelphia), and research studies (e.g., the Early Re-intervention experiments) where such transformations are underway, it is clear that the shift to a recovery management model entails changes in client engagement strategies, the assessment and service planning process, the service menu, the timing and duration of service delivery, the location of service delivery, the service relationships, and the relationship between treatment institutions and the local communities they serve (White et al., 2002; Dennis & Scott, in press).

One of the most profound changes in this model is its movement beyond brief stabilization to ongoing monitoring and intervention via telephone contact, recovery check-ups and early re-intervention, recovery coaching, and assertive linkage to communities of recovery. Research findings such as the following suggest that more assertive and long-term approaches to managing addiction hold great promise.

- The shorter the time span from first use to first treatment, the shorter the total years of use (Dennis et al., 2005).
- The more severe the substance use disorder, the less likely people are to seek help, but the amount of treatment in any year predicts who moves from addiction to recovery, and the amount of support group participation in any year predicts who stays in recovery (Scott et al., 2005a & b).
- Providing assertive continuing care increases the percentage of clients participating in post-treatment continuing care activities and improves recovery outcomes (Godley et al., 2002, in press).
- Providing recovery management checkups reduces the time from relapse to treatment readmission, increases treatment participation, increases rates of abstinence, and reduces future needs for treatment (Dennis et al., 2003).

Recovery management approaches also hinge on the recognition of multiple pathways and styles of long-term recovery. Such varieties of recovery experience are confirmed in our interviews with thousands of clients conducted months and years following an index episode of treatment. Yesterday's addiction counselor often worked within a particular pathway of recovery; tomorrow's addiction counselors will work across these pathways of recovery emphasizing a philosophy of choice with each client.

## Implications for Clinical Practice

Educate Stakeholders about the Implications of the Chronic and Cyclical Nature of Addiction. Given that many individuals seeking publicly funded treatment have a substance use disorder that will likely span several years and multiple episodes of treatment, educating stakeholders and successfully shifting expectations and attitudes about relapse are primary challenges. Educating clients and their families about the chronic and cyclical nature of addiction may help families sustain their support during times of relapse. Education of treatment staff will help them appropriately attribute relapses to the condition being treated rather than the person and result in less shame for clients and families. In addition, educating policy makers and funders will be crucial to both creating new financing models and changing regulatory standards to accommodate models of sustained recovery management.

Develop new models for treating individuals who need multiple episodes of care. Our current approach to treating chronic substance use disorders often leaves both clients and staff frustrated with burdensome readmission processes and repeated cycles of "treatment as usual" for individuals who return for multiple episodes of care. In fact, one clinical supervisor asked one of our study participants why she returned again and again for treatment when she had already been exposed to their treatment. The supervisor said "there's nothing more for you here." If the same array of services has not worked several times, is it sensible to provide the same services and expect a different outcome or ethical to abandon such clients by refusing further services?

It is important when running any business to understand why the services we provide do not adequately meet our customers' needs. In the addictions field, we need to understand why so many clients drop out of treatment early and/or continue to relapse. The problems may be logistical (e.g., a lack of transportation, childcare), social (e.g., a partner, social peers), or due to a lack of linkage to a community that supports recovery. In our follow-up interviews, we have been struck by the number of relapsed clients who experienced their requests for further help as a shaming ritual and who were often refused re-admission on the grounds that they would be taking a bed from someone who was more deserving or told that the program had nothing new to offer them. Disrespect (e.g., castigation as "retreads" or "frequent flyers") and abandonment seem to be the norm for clients with chronic addiction problems. It is ironic that the treatment system is least welcoming to those who need its services the most. We need a new approach for clients whose problems are marked by high severity and chronicity.

Utilize ongoing monitoring and early re-intervention to prevent and/or shorten the length of major episodes of relapse. Ongoing management of other chronic health conditions successfully controls the severity and progression of these conditions when such conditions cannot be cured. A core assumption underlying this approach is that long-term monitoring through regular checkups and early re-intervention facilitate early detection of relapse, reduce the time to treatment reentry and consequently improve long-term participant outcomes. This approach also does not rely on participants to self-identify their symptoms and return to treatment. Recovery checkups are pro-active and include quarterly assessments and personalized feedback for each

participant on the status of their condition. The clients we have interviewed for years often describe the value of these checkups in terms of empathy and acceptance, kindness and courtesy, belief in the client's capacity to change, respect for the client's right to learn from good and bad choices, linkage to crucial resources, and simply hanging in through the client's setbacks and successes.

Provide multiple avenues in addition to traditional treatment. There is growing evidence that the processes of recovery maintenance are different than the processes of recovery initiation (White & Kurtz, in press). While treatment as currently designed can be a boon to recovery initiation, it offers little support for long-term recovery maintenance for those with the most severe problems. Many returning clients need only the briefest of treatments to re-achieve biopsychosocial stabilization, but they often need a broad range of non-clinical recovery support services to sustain recovery over time. As models of recovery management emerge, treatment agencies will develop larger service menus and will collaborate with a much larger spectrum of community agencies in helping people both get sober and stay sober. Such resources will include the growing diversity of recovery mutual aid societies, the rapidly expanding network of recovery homes, new recovery support organizations (e.g., recovery support centers, faith-based recovery ministries, recovery schools, recovery work co-ops) and roles (e.g., recovery coaches).

One of the contributions of longitudinal studies is a clearer picture of the course of addiction and the affirmation of the potential for recovery even among those clients whose addictions are characterized by great severity, chronicity, and the need for multiple episodes of treatment. We have been humbled and inspired by the stories we have collected and hope you will benefit from the understandings we have tried to extract from these stories. The traditional concepts of "discharge" followed by brief "aftercare" have less meaning in the shift from acute care to recovery management models. To quote Dr. J. H. Kain (1828, p. 295), "Chronic diseases require chronic cures." His adage suggests the need to remain involved with clients to help them manage the prolonged course of both addiction and recovery.

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## AA and the Peer Recovery Support Revolution

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On May 12, 1935, two desperate men, Bill Wilson and Dr. Robert Smith, met in Akron, Ohio, each seeking escape from a disorder that had resisted innumerable efforts at self-cure and professional treatment. Their meeting stands as one of the milestone events in the birth of Alcoholics Anonymous (AA). Today, AA has a membership exceeding 2 million members spanning more than 100,000 local groups and 150 countries.

AA's rise to cultural prominence in America sparked secular recovery support group alternatives such as Women for Sobriety, SMART Recovery, Secular Organizations for Sobriety, LifeRing Secular Recovery and Moderation Management. Recovery support groups that were explicitly religious in their orientation also were inspired by AA's example. These include Alcoholics Victorious, Celebrate Recovery, Overcomers Outreach, Liontamers Anonymous, and Millati Islami. AA's Twelve Step program has also been adapted by new Twelve Step organizations to address more than 400 distinct problems, and AA has been the source of inspiration for an even larger array of mutual support groups that now dot the American landscape. In that process, "recovery" has become a metaphor for the process of resolving a broad spectrum of human problems.

AA has offered many gifts to the world—beyond its specific program of alcoholism recovery. AA affirmed the value of experiential knowledge in the helping process, extolled the legitimacy of the "wounded healer" (the idea that individuals who have survived an adverse experience or condition may have special abilities to help others similarly afflicted), and validated the "helper principle" (the helper benefits from the process of assisting others) all on a world-wide scale. AA also discovered the value of story reconstruction and storytelling in personal recovery and offered specific prescriptions for daily living as aids in the management of severe and complex problems.

The growth of American communities of recovery has led to the cultural and political awakening of recovering people and their families. This awakening is evident in the emergence of recovery advocacy movements, cultural revitalization movements (particularly within American

Indian and African American communities), and new grassroots recovery community organizations. In the addictions arena, local recovery advocacy organizations have banded together nationally under the linked umbrella of Faces and Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Johnson Institute and the Legal Action Center. The addiction recovery advocacy movement is spawning new cultural institutions that include volunteer-run community recovery centers, recovery homes/colonies, recovery schools, recovery industries, and recovery ministries/churches. Advocacy movements are focusing on social policy issues, but they are also calling upon traditional service organizations to shift their primary focus from acute problem stabilization to sustained recovery support.

The growth of these mutual aid and advocacy movements raises the question of how nonprofit community service organizations should relate to these movements. Based on my experience studying and facilitating these relationships, I would offer the following 12 prescriptions for nonprofit community service organizations.

1. Conduct a "searching and fearless" inventory of your organization's degree of responsiveness to the needs of the individuals, families and communities you serve e.g., conducting "town meetings" with multiple constituent groups, monitoring recovery-focused benchmark data, e.g., attraction, engagement, service quality, post-service check-ups, and long-term service outcomes.

2. Engage constituents in defining recovery, identifying a set of core recovery values and developing a recovery-focused vision statement to guide the work of your organization.

3. Cultivate a corporate identity that defines the organization and its staff as a part of and accountable to local communities of recovery.

4. Increase the representation of recovering people at all levels of the organization, and provide formal mechanisms for participation in organizational decision-making, e.g., board representation, a consumer advisory council.

5. Establish formal linkages between your organization and service committees of local recovery support groups and recovery advocacy organizations.

6. Encourage all staff, volunteers and consultants to become students of local cultures of recovery, e.g., become knowledgeable of respective recovery philosophies and meeting rituals, explore the rapidly growing world of Online recovery support meetings and resources, participate in open meetings of local support groups, and financially support and participate in local recovery celebration activities.

7. Involve indigenous recovery support resources from the community within agency-sponsored service activities, e.g., the development of strong volunteer programs and alumni associations.

8. Recruit people in recovery as paid recovery coaches or volunteer peer support specialists and to fill other professional and technical roles.

9. Embrace a "philosophy of choice" that acknowledges the legitimacy of multiple pathways and styles of long-term recovery and empowers clients to manage their own long-term recovery processes.

10. For each client, transition as quickly as possible from professionally-directed service plans to client-directed recovery plans; cultivate

assertive and sustained approaches to post-treatment continuing care.

11. Utilize community organization and community development techniques to expand local recovery support resources.

12. Enter into partnership with local recovery community organizations to jointly advocate on issues of shared concern (including issues that transcend the financial interests of your organization).

In recent decades, local nonprofit community service organizations were encouraged to see themselves as businesses—to emulate the management, marketing, and financial acumen of the private for-profit sector. Many of us achieved this goal and have organizations whose budgets, facilities and staffing levels would have been unthinkable in our earlier professional years. And yet there are the pangs of fear that something of great value is being lost through the professionalization and industrialization of the helping process. Some fear lost contact with our historical missions or that we have lost contact with the grassroots communities out of which we were born. And long-tenured workers lament a world more focused on a progress note signed by the right color of ink rather than whether clients are making progress.

The spread of mutual support movements, new recovery community organizations, and new recovery advocacy movements is a call for us to fully re-enter the lives of our communities. In a service world too often marked by ever-briefer contact, impersonality, and excessive preoccupations with money and regulatory compliance, there seems to be a rising cry for helping relationships that are reciprocal, enduring and non-commercialized. Entering into true partnership with these movements can achieve many goals, including the elevation of service quality and the effective stewardship of limited community resources. Reaching out to these grassroots movements also affords a wonderful opportunity for personal, professional and organizational renewal.



# Selected Papers of William L. White

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## Recovery Capital: A Primer for Addictions Professionals

**William L. White, MA and William Cloud, PhD**

### From Pathology to Resiliency and Recovery

The history of addiction treatment in America contains within it a history of key ideas that have transformed service philosophies and practices. In the early history of modern treatment, for example, *chemical dependency* emerged as a core idea that helped integrate what were then two separate fields: one focused on alcoholism, the other on drug addiction. Other concepts, such as *codependency*, *dual diagnosis*, *gender-specific*, *developmental appropriateness*, *cultural competence*, *trauma-informed*, *evidence-based*, *stages of change, motivational enhancement, recovery management*, and *recovery coaching* helped, or are now helping, transform addiction treatment into a more person-centered, holistic, family-centered, and recovery-focused system of care.

Addiction professionals across America are witnessing the field's paradigmatic shift from a pathology and intervention focus to a recovery focus (White, 2004, 2005). Attention on the lived solution to alcohol and other drug (AOD) problems is reflected in the growing interest in defining recovery, conducting recovery prevalence surveys, illuminating the varieties of recovery experiences, and mapping the patterns, processes, and stages of long-term recovery (Betty Ford Institute Consensus Panel, 2007; White & Kurtz, 2006).

One of the key ideas at the core of this shift is that of *recovery capital*. This article defines recovery capital and explores how attention to recovery capital can be integrated into the service practices of front-line addiction professionals.

### Recovery Capital Defined

Recovery capital (RC) is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Cloud & Granfield, 2004). Recovery capital is conceptually linked to natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience and protective factors, and the ideas of hardiness, wellness, and global health. There are three types of recovery capital that can be influenced by addictions professionals.

*Personal recovery capital* can be divided into physical and human capital. A client's physical recovery capital includes physical health, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Human recovery capital includes a client's values, knowledge, educational/vocational skills and credentials, problem solving capacities, self-awareness, self-esteem, self-efficacy (self-confidence in

managing high risk situations), hopefulness/optimism, perception of one's past/present/future, sense of meaning and purpose in life, and interpersonal skills.

*Family/social recovery capital* encompasses intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Family/social recovery capital is indicated by the willingness of intimate partners and family members to participate in treatment, the presence of others in recovery within the family and social network, access to sober outlets for sobriety-based fellowship/leisure, and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

*Community recovery capital* encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug problems. Community recovery capital includes:

- active efforts to reduce addiction/recovery-related stigma,
- visible and diverse local recovery role models,
- a full continuum of addiction treatment resources,
- recovery mutual aid resources that are accessible and diverse,
- local recovery community support institutions (recovery centers / clubhouses, treatment alumni associations, recovery homes, recovery schools, recovery industries, recovery ministries/churches), and
- sources of sustained recovery support and early re-intervention (e.g., recovery checkups through treatment programs, employee assistance programs, professional assistance programs, drug courts, or recovery community organizations).

*Cultural capital* is a form of community capital. It constitutes the local availability of culturally-prescribed pathways of recovery that resonate with particular individuals and families. Examples of such potential resonance include Native Americans recovering through the "Indianization of AA" or the "Red Road," or African Americans recovering within a faith-based recovery ministry or within an Afrocentric therapeutic orientation (Coyhis & White, 2006; White & Sanders, in press).

In total, recovery capital constitutes the potential antidote for the problems that have long plagued recovery efforts: insufficient motivation to change AOD use, emotional distress, pressure to use within intimate and social relationships, interpersonal conflict, and other situations that pose risks for relapse.

## Early Scientific Findings

Modern addiction science has illuminated critical factors that contribute to the onset and complicate the course of substance use disorders, e.g., a family history of AOD problems, childhood victimization, early age of unsupervised AOD use, multiple drug use, injection drug use, long delay from onset of AOD problems to first treatment, high emotional distress (co-occurring psychiatric illness), and enmeshment in an AOD-saturated social milieu (See White, in press/a for a review). But the protective factors that can offset such risk factors or increase one's odds of successful long-term addiction recovery have yet to be fully charted. The following key findings from recent scientific studies and reviews underscore the potential importance of recovery capital.

- Recovery capital—both its quantity and quality—plays a major role in determining the success or failure of natural and assisted recovery (e.g., recovery from AOD problems without or with participation in professional treatment or a recovery mutual aid society) (Granfield & Cloud, 1996, 1999; Moos & Moos, 2007; Kaskutas, Bond, & Humphreys, 2002).
- Increases in recovery capital can spark *turning points* that end addiction careers, trigger recovery initiation, elevate coping abilities, and enhance quality of life in long-term recovery (Cloud & Granfield, in press; Laudet, Morgan, & White, 2006).

- Such *turning points,* both as climactic transformations and incremental change processes, may require the accumulation of recovery capital across several years and multiple episodes of professional treatments (Dennis, Foss, & Scott, 2007).
- Elements of recovery capital vary in importance within particular stages of long-term recovery (Laudet & White, in press).
- Recovery capital is not equally distributed across individuals and social groups. Members of historically disempowered groups often seek recovery from addiction lacking assets that are taken for granted by those seeking recovery from a position of privilege (Cloud & Granfield, 2001).
- Post-treatment recovery check-ups, and, when needed, early re-intervention can help preserve the recovery capital developed through addiction treatment (Dennis, Scott, & Funk, 2003).
- Most clients with severely depleted family and community recovery capital gain little from individually-focused addiction treatment that fails to mobilize family and community resources (Moos & Moos, 2007).
- Long-term recovery outcomes for those with the most severe AOD problems may have more to do with family and community recovery capital than the attributes of individuals or a particular treatment protocol (Bromet & Moos, 1977; Humphreys, Moos, & Cohen, 1997; Mankowski, Humphreys, & Moos, 2001).

Science is confirming what front-line addiction professionals have long known: "environmental factors can augment or nullify the short-term influence of an intervention" (Moos, 2003, p. 3). This suggests that therapeutic processes in addiction treatment must encompass more than a strictly clinical intervention (Simpson, 2004). Strategies that target family and community recovery capital can elevate long-term recovery outcomes as well as elevate the quality of life of individuals and families in long-term recovery (White, in press/b).

**Recovery Capital and Clinical Practice**

Heightened attention to recovery capital can significantly influence one's service delivery practices. The following prescriptions reflect such attention.

1. Support screening and brief intervention (SBI) programs that reach people before their recovery capital is depleted and substance use disorders have become severe, complex, and chronic (Cloud & Granfield, 1994a). SBI programs are sometimes viewed as tools of case finding and induction for addiction treatment, but their greatest value is in helping people resolve AOD problems using personal, family, and community resources before specialty-sector professional treatment is needed. To achieve such a goal, we must all become students of the processes through which AOD problems in the larger community are resolved.

2. Engage people with low recovery capital through aggressive programs of community outreach. "Hitting bottom" only has meaning when there is still personally meaningful recovery capital to be lost. When recovery capital is exhausted, people will die before such a mythical bottom is reached. The obstacle to recovery under such conditions is not insufficient pain, but the absence of hope, connectedness, and potential for fulfillment. People with severely depleted RC have unfathomable capacities for physical and psychological pain. We must go get people with high problem severity and extremely low recovery capital rather than wait for their pain or coercive institutions to bring them to us. The catalytic turning point for those with depleted recovery capital is more likely to be one of seeing an achievable top than hitting bottom.

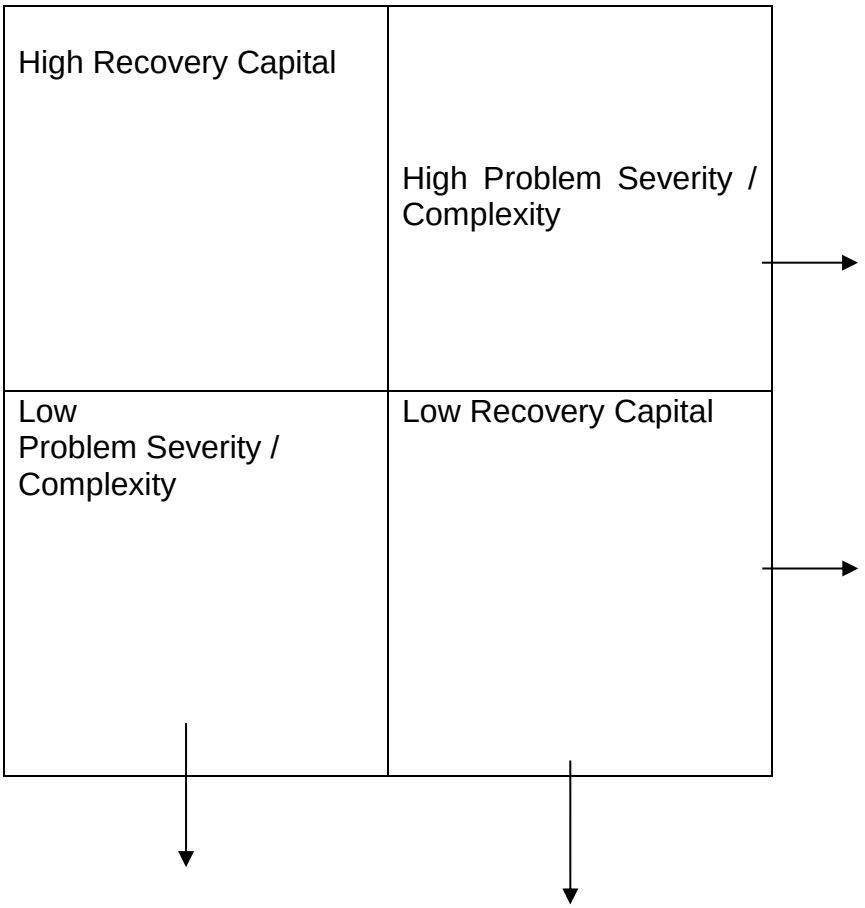
3. Assess recovery capital on an ongoing basis. Traditional assessment technologies in addiction treatment are distinctly pathology-focused. Addiction professionals have been trained to employ assessment instruments and interview protocols to generate a problems list that forms the basis of treatment planning activities. Growing evidence on the

role of recovery capital in AOD problem resolution calls for a more strengths-based approach to the assessment process. The fact that recovery capital ebbs and flows through both addiction and recovery careers also calls for a continual assessment process that can identify subtle but crucial shifts in recovery assets. The AOD cessation capacity of each individual at a particular point in time might well be thought of as the interaction between problem severity and recovery capital.

4. Use recovery capital levels to help determine level of care placement decisions.

Traditional placement models link problem severity and intensity of care. Those with high problem severity and complexity are placed in the most restrictive levels of care, e.g. inpatient and residential programs, and are provided the longest course of professional care. This formula misses the crucial influence on recovery capital. The figure below illustrates four potential interactions between problem severity/complexity and recovery capital (Figure and discussion abstracted from White, in press/a).

Figure 1: Recovery Capital / Problem Severity Matrix




Factoring in the unique combination of a client's problem severity can alter placement decisions.

- A client with moderate problem severity but high recovery capital arriving at a treatment agency in response to a positive drug test might be quite appropriate for screening and brief intervention. Such individuals often terminate addictions on their first attempt without professional or peer assistance and without embracing an addiction/recovery-based personal identity (Granfield & Cloud, 1996; Cloud & Granfield, 1994b). They can also often be helped through non-specialty helping institutions, culturally indigenous support institutions (e.g., cultural revitalization movements), or from peer-based

recovery support groups without facing the cost, life disruption or stigma associated with addiction treatment (Cloud & Granfield, 1994a,b). This same individual with multiple risk factors (e.g., family history, early onset of use, etc.) might be appropriate for SBI followed by periodic recovery check-ups as a means of lowering the risks for future problem escalation.

- A client with high problem severity and complexity but exceptionally high recovery capital might be appropriate for outpatient detoxification and outpatient treatment despite a level of problem severity that, viewed in isolation, would justify inpatient care. Assertive linkage to recovery mutual aid groups in tandem with motivational interviewing and ongoing recovery check-ups might well serve as an alternative to inpatient or residential treatment.
- A client with low problem severity but high risk factors and extremely low recovery capital might be in greater need of residential treatment and step down care than the above profiled clients, even though he or she is likely to end up with SBI or outpatient treatment within current assessment and placement systems.
- A client with high problem severity/complexity and extremely low recovery capital requires services of high intensity, broad scope (e.g., outreach, assertive case management, and sustained recovery coaching), and long duration (Cloud & Granfield, 2001, 2004; White, in press,a). Providing such clients brief treatment isolated from their natural environment and then "graduating" them into that same environment without substantial community-based supports is a set-up for failure. Clients from historically disempowered communities are often punished (e.g., lost custody of children, incarceration) following such "failures" on the grounds that they "had their chance" (White & Sanders, in press).

5. Target all three spheres of recovery capital within professionally-directed treatment plans and client-directed recovery plans. The question is: What resources need to be mobilized within the individual, the family/social milieu, and the community to support the long-term recovery of each client? The Native American Wellbriety movement uses the metaphor of the "healing forest" to underscore the inextricable link between personal, family, and community health. Treatment and recovery plans that reflect this understanding include interventions to elevate family and community recovery capital and assertively link clients and families to other individuals, families, and community institutions rich in recovery capital.

6. Support recovery-linked cultural revitalization and community development movements. One of the ways addiction professionals can increase the recovery capital of the individuals and families they serve is to actively support local movements aimed at increasing recovery support services and creating a community milieu within which recovery can flourish. Such support could include serving on the board of a recovery community organization, volunteering at a recovery support center, encouraging those seeking to start a new recovery support group, participating in recovery education or recovery celebration events, and providing financial contributions to help promote and conduct such events.

7. Use changes in levels of recovery capital to evaluate your program and your own professional performance. The most effective addiction treatment programs help build community recovery capital beyond their own service programs. This can be done by regularly assessing aggregate community recovery capital, issuing a periodic report card on community recovery resources, and by allocating organizational resources to support recovery community development activities. If non-treatment community recovery capital decreases in tandem with the growth of treatment services, the community is being inadvertently wounded by treatment expansion. One of the best ways to assess the impact of treatment resources is to evaluate whether they generate long-term increases or decreases in community recovery capital.

At a personal level, we tend to evaluate our effectiveness based on what is subtracted

from the lives of our clients (e.g., AOD use, criminal activity, threats to public safety, financial problems, high health care consumption, and emotional distress). But the short-term elimination or reduction of these ingredients may or may not have any linkage to the prospects of long-term recovery. A better predictor of long-term recovery may be what has been added to the lives of the individuals and families with whom we work, e.g., radically altered perceptions of alcohol and other drugs, physical and emotional health, increased coping and communication skills, improved family relationships, new family rules and rituals, safe/stable housing and employment; clean and sober friends, membership in a community of recovering people, and life meaning and purpose.

**Summary**

The concept of recovery capital reflects a shift in focus from the pathology of addiction to a focus on the internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems. As this concept permeates the field, addiction treatment programs will increase their involvement with families and communities, and addiction professionals will become more involved in recovery community building activities. Recovery capital has a contagious quality. It is time we all became its carriers.

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## Recovery Capital as Prospective Predictor of Sustained Recovery, Life Satisfaction and Stress among Former Poly-substance Users

### Abstract

Many recovering persons report quitting their drug use because they are "sick and tired" of the drug life. Recovery is the path to a better life, but that path is often challenging and stressful. There has been little research on the millions of recovering persons in the United States, and most research has focused on substance use outcomes rather than on broader functioning domains. This study builds on our previous cross-sectional findings that recovery capital (social supports, spirituality, religiousness, life meaning, and 12-step affiliation) enhances the ability to cope with stress and enhances life satisfaction. This study (a) tests the hypothesis that higher levels of recovery capital prospectively predict sustained recovery, higher quality of life, and lower stress one year later, and (b) examines the differential effects of recovery capital on outcomes across the stages of recovery. Recovering persons (N = 312), mostly inner-city ethnic minority members whose primary substance had been crack or heroin, were interviewed twice at a one-year interval in New York City between April 2003 and April 2005. Participants were classified into one of four baseline recovery stages: under 6 months, 6-18 months, 18-36 months, and over 3 years. Multiple regression findings generally supported the central hypothesis and suggested that different domains of recovery capital were salient at different recovery stages. The study's limitations are noted and implications of findings for clinical practice and for future research are discussed, including the need for a theoretical framework to elucidate the recovery process.

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## Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities

**William L, White, MA and Mark Sanders, LCSW, CADC**

### Abstract

*Communities of color have been ill-served by acute care models of treating severe alcohol and other drug (AOD) problems that define the source of these problems in idiopathic (biopsychological) terms and promote their resolution via crisis-elicited episodes of brief, individual interventions. This article explores how approaches that shift the model of intervention from acute care (AC) of individuals to a sustained recovery management (RM) partnership with individuals, families and communities may be particularly viable for historically disempowered peoples. The advantages of the RM model for communities of color include: a broadened perspective on the etiological roots of AOD problems (including historical/cultural trauma); a focus on building vibrant cultures of recovery within which individual recoveries can be anchored and nourished; a proactive, hope-based approach to recovery engagement; the inclusion of indigenous healers and institutions with the RM team; an expanded menu of recovery support services; culturally-grounded catalytic metaphors and rituals; and a culturally- nuanced approach to research and evaluation.*

**Key Words**: Addiction, chronic disease, recovery management, African American, Native American

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### Introduction

Addiction has been characterized as a “chronic, progressive disease” for more than 200 years (White, 2000a), but interventions into severe alcohol and other drug (AOD) problems continue to be based on serial episodes of self-encapsulated, acute intervention (O’Brien and McLellan, 1996; Kaplan, 1997). Recent research has confirmed the chronic nature of severe AOD

problems (Hser, Anglin, Grella, Longshore, & Pendergast, 1997; Scott, Foss, & Dennis, 2005) and compared such problems to other chronic health disorders (e.g., type 2 diabetes mellitus, hypertension and asthma) in terms of their etiological complexity, variability of course, and recovery and relapse rates (McLellan, Lewis, O'Brien, & Kleber, 2000). Calls for shifting addiction treatment from an acute care (AC) model to a model of sustained recovery management (RM) are increasing (White, Boyle, & Loveland, 2002, 2003; Compton, Glantz, & Delaney, 2003; Edwards, Davis, and Savva, 2003), and components of such models are currently being evaluated with adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002) and adults (Dennis, Scott & Funk, 2003; Scott, Foss & Dennis, 2005b). The emerging model of recovery management has been defined as:

> *…the stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a timesustained, recovery-focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe behavioral health disorders until full remission has been achieved or until recovery maintenance can be self-managed by the individual and his or her family* (White, Boyle, Loveland & Corrigan, 2003).

This article contrasts the application of AC and RM models of intervention into severe AOD problems within communities of color. We will focus specifically on those American Indian/Alaskan Native, African American, Hispanic/Latino and Asian and Pacific Islander communities whose members present unique obstacles and resources as they enter publicly funded treatment for severe AOD problems. Our contrast of AC and RM models is drawn from the pioneering work of McLellan, Lewis, O'Brien and Kleber (2000) and from descriptions of the changes in clinical practice within the RM model (White, Boyle & Loveland, 2002, 2003; White, 2005; Scott, White & Dennis, 2007). We argue that historically disempowered persons, and, in particular, communities of color, have been ill-served by acute, biomedical models of intervention into AOD problems, and that models of recovery management hold great promise in providing more effective solutions to AOD problems within these communities. Great care must be taken that discussions of the needs of communities of color do not inadvertently contribute to stereotypes about these communities. To determine whether RM models of intervention hold greater promise than AC models, we will need to explore those characteristics of communities of color that have relevance to the viability of these models. Given the enormous differences within and between ethnic communities and the changes in these communities over time, we would ask readers to keep all observations, ideas and strategies set forth in this article on probation pending their validation within particular communities and with particular individuals and families. "People of color" and "communities of color" do not constitute a monolithic group to which a single explanatory or intervention model can be indiscriminately applied. Testing components of the RM model will need to be conducted in all ethnic communities and across multiple subpopulations within those communities. We hope this introductory paper will stand as an invitation for such sustained exploration.

We will begin by contrasting how AC and RM models conceptualize the sources and solutions to AOD problems and then explore the RM model's emphasis on proactive engagement, the use of indigenous healers and institutions, catalytic rituals and metaphors, new technologies of monitoring and recovery support, a sustained recovery management partnership, and the need for culturally-nuanced approaches to research and evaluation.

## AC and RM Models: The Source of AOD Problems

> *American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon,…contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism and other social problems among American Indians.*--Brave Heart and DeBruyn, 1998
>
> *When people are taught to hate themselves, they will do bad things to themselves*. --Sanders, 1993.

Acute care (AC) models of intervention have assumed that the sources and solutions to AOD problems reside within the individual, and that brief interventions to alter an individual's physical, cognitive and emotional vulnerabilities can produce a permanent resolution of these problems. RM models posits that AOD problems spring from multiple, interacting etiologies; unfold (suddenly or progressively) in highly variable patterns; ebb (remission) and flow (relapse) in intensity over time; and are resolved at different levels (from full to partial) via multiple long-term pathways of recovery. People of color may be at risk for AOD problems, but these risk factors differ between and within ethnic groups (Matsuyoshi, 2001).

The RM model suggests that historical, political, economic, and sociocultural circumstances can also serve as etiological agents in the rise of AOD problems. Client discussions about cultural pain (e.g., slavery, the loss of land, attempted extermination, epidemic diseases, the purposeful break-up of tribes and families, the loss of families and culture via immigration or forced deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism and discrimination) are viewed, not as defocusing or acting out, but as a medium of a consciousness raising and catharsis that can open doorways to personal/community healing and transformation (Green, 1995). This approach is much more congruent with beliefs within communities of color that their AOD problems result as much from historical trauma[1], economic and political disempowerment, and cultural demoralization as from biological vulnerability (Manson, 1996; Brave Heart & DeBruyn, 1998; Brave Heart, 2003). Culturally-nuanced models of RM reflect an understanding of the effects of intergenerational trauma (grief, rage, self-hatred, self-medication) upon whole communities. Positing multiple pathways of long-term recovery also opens up the potential for culturally prescribed frameworks of AOD problem resolution (abstinence-based religious and cultural revitalization movements, e.g., the Nation of Islam) as well as cultural adaptations of existing recovery support structures (e.g., the "Indianization" of Alcoholics Anonymous and the adaptation of A.A. within Hispanic/Latino communities) (Womak, 1996; Hoffman, 1994).

RM models assume that severe AOD problems constitute complex, chronic disorders that require sustained individual, family, community and cultural interventions for their long-term resolution. In this view, treating severe and persistent AOD problems via AC models of intervention is as ineffective as treating a bacterial infection with half the effective dose of antibiotics. Such treatment may temporarily suppress symptoms, but often results in the subsequent return of the problem in a more virulent and treatment-resistant form. In the RM model, the treatment of severe and

[1] Maria Yellow Horse Brave Heart (2003) has defined historical trauma as "cumulative emotional and psychological wounding over the lifespan and generations, emanating from massive group trauma experiences."

persistent AOD problems is delivered within a sustained recovery management partnership that provides ongoing recovery support and consultation and anchors the recovery process in indigenous supports within the client's natural environment.

Chronic disorders such as diabetes and heart disease take an undue toll on communities of color, but substantial efforts are underway within communities of color for the prevention, early intervention, and sustained management of such chronic health problems. As communities of color learn more about the nature and treatment of chronic primary health disorders, that knowledge base can be extended to severe AOD problems. There is already some recognition of addiction as a chronic disorder via people of color sustaining hope for a family member or friend's recovery, long after the rest of the world has lost such hope. That capacity for patience, compassion and forgiveness is not a sign of pathology (codependency), but an unheralded resource of hope and support within communities of color that the RM model seeks to build upon.

The acute care model rests on the assumption that AOD problems are self-contained and that individuals have the internal and external resources to sustain recovery and assume full social functioning following detoxification and brief treatment. It assumes a foundation of pre-morbid skills and social functioning. This rehabilitation model promises the client that he or she will regain prior levels of functioning and status lost via the accelerating severity of AOD problems. This model is poorly suited for individuals who have not achieved such prior levels of successful functioning and who have few if any significant supports for recovery within their families and social networks. The model is particularly unsuited for those poor communities of color whose members present with high AOD problem severity, numerous co-occurring problems, and low "recovery capital" (internal and external resources that help to initiate and maintain recovery) (Granfield and Cloud, 1999).

In contrast, the RM model assumes that clients have widely varying degrees of problem severity and recovery capital and that the degree and duration of need for recovery support services requires differential allocation of services across these levels of functioning. Where levels of care within traditional treatment are dictated primarily by problem severity, RM models set service intensities and duration based on the unique interaction of problem severity and recovery capital. For those with little recovery capital, RM provides a framework for sustained habilitation.

**The RM Solution: Personal, Family and Community Renewal**

*Ultimately, it is the community that cures....To cure the wounded, one need only return them to their community or construct a new one.* --Philip Rieff, 1987

*Community healing along with individual and family healing are necessary to thoroughly address historical unresolved grief and its present manifestations*. --Brave Heart and DeBruyn, 1998

The unit of service within the AC model is the individual with an AOD problem. Professional interventions are designed to lower the biological vulnerability and alter the beliefs and behaviors thought to sustain addiction. When the AC model fails to resolve AOD problems, the root of that failure is viewed as residing inside the individual. The professional response, in practice if not in theory, is to prescribe additional repetitions of the failed intervention. Of people admitted to publicly funded addiction treatment in the U.S., 64% already have one or more prior admissions, including 22% with 3-4 prior admissions and19% with 5 or more prior admissions (OAS, 2005). An aggressive system of managed behavioral health care has lowered the intensity and duration of these treatment episodes, further lessening the viability of addiction treatment for persons within communities of color who present with

the highest problem severity, complexity and chronicity.

Within the RM model, individuals with AOD problems are viewed as being nested within a complex web of family, social and cultural relationships. Each level of this social ecosystem can contribute to the development of, help resolve, or sabotage efforts to resolve these problems. As a result, it is the whole ecosystem rather than the individual that is the target of the RM intervention. RM moves beyond the clinical skills of assessment, diagnosis and treatment of individuals to encompass the skills of family reconstruction, community resources development, and nation-building (see the work of White Bison, Inc. for examples of the latter). RM in communities of color is premised on the belief that connection to community is an essential dimension of personal healing. In the AC model, the family is a stimulus for help-seeking, a source of emotional and financial support for treatment retention, and a target for brief education and referral to peer-support (e.g., Al-Anon). The assumption is that whatever wounds the family suffered through the addiction experience will naturally and quickly reverse themselves following the addicted family member's recovery initiation. In contrast, the RM model is based on the following six assumptions about the impact of addiction on the family and the family's role in the recovery process.

1) Addiction is but one wound families of color have suffered via the intergenerational transmission of historical trauma (e.g., the forced breakup of family units in slavery, the Indian boarding schools and their prolonged aftermath, traumatic separation via immigration) and that the family unit itself needs a sustained process of recovery from these wounds (Brave Heart and DeBruyn, 1998).
2) The addiction-related transformation of family roles, relationships, rules and rituals are deeply imbedded within family members, and habitual patterns of family interaction will not spontaneously remit with recovery initiation.
3) There are developmental stages of family recovery that entail personal healing, a realignment of family subsystems (adult intimate relationship, parent-child relationships, and sibling relationships), and the families relationship with the outside environment—tasks that consume the first 3-5 years of stable recovery (See Brown and Lewis, 2002).
4) Families who do not have sufficient supports to make these difficult transitions are at high risk for disintegration—in spite of their having remained intact through years of addiction (Brown and Lewis, 2002).
5) Sustained recovery monitoring and support for family members is as crucial as it is for the individual recovering from severe AOD problems. 6) RM services for families need to be refined based on the unique family and kinship patterns that exist within particular ethnic communities.

The importance of community in understanding AOD problems within communities of color is perhaps most evident within the rising Wellbriety movement in Indian Country. A central idea within this movement is the "Healing Forest" metaphor developed by Don Coyhis (1999). In Coyhis' work, the AC model of treatment is analogous to removing a sick tree from diseased soil, nursing it back to health in well-fertilized and well-watered soil and then returning it to the diseased soil from which it came. Coyhis suggests that we would need fewer tree hospitals if we treated the trees AND the soil in which the trees suffer or thrive. He calls for the creation of a "healing forest" to nurture sobriety and wellness. This broader vision of creating healthy communities that resist AOD problems and within which recovery can thrive is pervasive in communities of color but is markedly absent within the professional field of addiction treatment.

In communities of color, the individual, the family and the community are inseparable. To wound one is to wound the other; to heal one is to heal all (Red Road to Wellbriety, 2002). When interviewed about how the Shuswap tribe in Alkali Lake, British Columbia successfully reduced its alcoholism rate from nearly 100% to less than 5%, Chief Andy Chelsea declared simply, "the community is the treatment center" (quoted in Abbot, 1998; See also Chelsea & Chelsea, 1985 & Taylor, 1987). The most effective and enduring solutions to AOD problems among people of color are ones that emerge from within the very heart of communities of color. The RM model seeks to tap this vein of resistance and resilience by recognizing and enhancing the recovery support capacities of families, kinship networks, indigenous institutions (e.g., mutual aid groups, churches, clans) and whole communities and tribes.

**Proactive Engagement**

> *My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope*. —Outreach Worker (Quoted in White, Woll, & Webber, 2003)

The AC model of intervention is essentially crisis-oriented. It relies on internal pain or external coercion to bring individuals to treatment, and places the responsibility for motivation for change squarely and solely on the individual. It assumes that people move from addiction to recovery when the pain of the former state reaches a point of critical mass. The AC model is also characterized by a high threshold of engagement (extensive admission criteria and procedures), high rates of client disengagement (terminating services against staff advice) and high rates of client extrusion ("administrative discharge" for non-compliance) (White Scott, Dennis & Boyle, 2005).

In contrast, the RM model is characterized by assertive models of community outreach, pre-treatment recovery support services, and a proactive approach to the resolution of personal and environmental obstacles to recovery. Motivation for recovery is not assumed to be static—a dichotomous (you have it or you don't) entity. It is assumed that such motivation waxes and wanes and that active recovery coaching can help the client transcend periods of heightened ambivalence, diminished confidence and recovery-induced anxiety. One of the earliest examples of such proactive outreach was the work of the East Harlem Protestant Parish among New York City's Puerto Rican heroin addicts in the 1950s. This faith-based program recruited addicts from the streets and enmeshed them within pro-recovery social clubs and a larger religious community (White, 1998).

The proactive engagement of the RM model is particularly suited for individuals whose personal/cultural experiences have engendered an exceptionally high physical and emotional tolerance for pain and for those who have never known anyone in recovery. Proactive engagement is also important for people of color who:

- lack the knowledge, skills and financial resources required to navigate complex health and human service systems;
- fear bringing shame to their families (losing "face") by breaking prohibitions on disclosing personal problems outside the family or kinship network--shame dramatically enhanced for women,
- have had negative experiences within or distrust formal service systems,
- bring special obstacles to accessing services (e.g., language barriers, illegal status), and
- possess beliefs about illness and health that conflict with the explanatory metaphors of mainstream service systems.

The RM model of engagement is particularly well suited for people of color whose resistance to treatment flows from the inertia of hopelessness. RM models place great emphasis on working within the pre-action stages of change and the long-term maintenance stages of change (Prochaska, DiClemente, & Norcross, 1992).

Of all the obstacles that proactive engagement is designed to address, perhaps the most difficult in both AC and RM models is the issue of language. Key informants from many ethnic communities emphasized the need for more bilingual professionals and service volunteers. This language barrier will need to be overcome if RM models are to fulfill their potential within ethnic communities. The outreach and assertive continuing care functions, in particular, will require a high level of cultural and linguistic fluency. The RM emphasis on building service capacity within communities offers some hope for expanding such competence.

While this assertive model of engaging and supporting individuals through the stages of recovery is well-suited to the obstacles and complex needs presented by many people of color, great care will need to be taken with this aspect of the RM model. The values of benevolence, generosity and service co-exist with the value of noninterference in the affairs of others within communities of color. The implementation of RM models in communities of color will require considerable care to avoid violating this latter value. The key will be to use RM's assertive approach to engagement and post-treatment monitoring and support, but to do so only with the continuing consent of the community, family and individual client.

Another dimension of the RM model (emerging from its view of multiple pathways of recovery) is its respect for the power and legitimacy of transformative change (change that is unplanned, positive and permanent) as a medium of recovery initiation (Miller and C'de Baca, 2001). Non-ordinary experiences (e.g., dreams, visions, climactic conversions) have long marked a pathway of addiction recovery for people of color, particularly among those who have led religious and cultural revitalization movements (e.g., Handsome Lake, Malcolm X). In contrast to the conversion style of induction, recovery may also be marked by a reaffirmation and deepening of existing religious/spiritual beliefs and practices, as Morjaria and Orford (2002) found in their study of South Asian American men (see also Manik, et al, 1997).

Where traditional AC models of treatment tend to discount the power and durability of religious experiences and the role of religious institutions as viable sobriety-based support structures, the RM model celebrates the legitimacy of these experiences and support institutions. Sustained sobriety can be a byproduct of religious and cultural affiliation and heightened ethnic identity, whether this occurs within the Nation of Islam, the Indian Shaker Church or a Buddhist or Hindu Temple. Such recoveries involve not just a redefinition of personal identity, but a redefinition of oneself as an *Indian, African American, Latino* or *Asian* person. For example, Spicer's studies of recovery in Native American communities found that recovery initiation was associated with heightened Indian identity and the incompatibility between drinking and emerging beliefs about how Indian people should conduct their lives (Spicer, 2001). This recognition of the power of culturally mediated transformative change provides a foundation of respect upon which RM-based organizations can collaborate with religious and cultural revitalization movements within communities of color.

**Indigenous Healers/Institutions and the Recovery Management Team**

> *Many individuals maintain sobriety only after they resume or begin regular involvement in traditional spiritual practices*. --Brave Heart and DeBruyn, 1998
>
> *The persistence and revival of indigenous Amerindian healing is due not to a lack of modern treatment services, but to a need for culture-*

*congenial and holistic therapeutic approaches*. –Jilek, 1978

AC treatment interventions are delivered by an interdisciplinary team of physicians, nurses, psychologists, social workers, and addiction counselors. The RM model, recognizing other dimensions of AOD problems (e.g., economic, political, cultural, spiritual, religious), broadens the recovery management team to include indigenous community institutions and healers. People of color utilize cultural healing therapies as alternatives or adjuncts to mainstream medicine and psychiatry, with the majority not reporting use of these alternative therapies to their mainstream service providers (Keegan, 1996).

Studies of the course of alcohol problems among American Indians have found remission/recovery rates as high as 60%, with few such recoveries attributable to formal alcoholism treatment (Spicer, 2001). American Indians have a long history of abstinence-based religious and cultural revitalization movements, indigenous healers as mediums of alcoholism recovery, and the use of Native medicines and ceremonies as adjunctive supports for recovery (White, 2000b; Coyhis & White, 2006). Growing awareness of this history has spurred calls for culture-congenial therapeutic approaches via an integration of Western treatment methods and traditional Native American healing practices (Jilek, 1974; Weibel-Orlando, 1987; Westermeyer, 1996). There is similar evidence for indigenous recovery frameworks in the Hispanic/Latino (Thomas, 1967; Singer and Borrero, 1984; Núñez Molina, 2001), Asian (Das, 1987; Yamashiro, & Matsuoka, 1997) and African-American communities (Leong, Wagner, & Tata, 1995). These indigenous recovery frameworks place great emphasis on the healing power of *regalos*—cultural values and ceremonies. The RM model is open to the inclusion of such institutions and their representatives within the recovery management team. In the RM model, the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist may each play a role within the RM team.

A recent evaluation of gender-specific addiction treatment programs in Illinois found that a significant number of recovering and recovered African American women are using the Black Church as their primary sobriety-based support structure, but most do so only months after initiating recovery and addressing issues of shame related to their addiction (White, Woll & Webber, 2003). Similar documentation exists on the use of religious frameworks of addiction recovery in other communities of color (Núñez Molina, 2001; Coyhis & White, 2006). This raises an interesting point about the differences between how individuals initiate recovery versus how they sustain that recovery over time. More specifically, it suggests that some clients of color may use one institution to initiate recovery (e.g., professionally-directed treatment, Alcoholics Anonymous or Narcotics Anonymous), but use culturally indigenous institutions to sustain recovery (e.g., the Black Church). Failure to sustain recovery could thus be viewed not as a need for more recovery initiation services (the AC treatment model), but a need to find a cultural pathway of long-term recovery maintenance (the RM model).

The RM model assembles professional and indigenous service teams to meet the unique recovery support needs of each client and family. The rationales for the use of such non-traditional teams are to expand the recovery support services available to individual clients and to decrease the number of people needing professional services by expanding natural recovery supports within the larger community. The inclusion of indigenous healers and recovery support institutions rests on a simple assumption: the natural community is an oasis of human and spiritual resources that can be tapped to resolve personal and family problems (McKnight, 1995). In the RM model, the centerpiece of recovery is not the treatment institution, but the client and his or her relationship to this larger community.

The inclusion of non-traditional roles within the RM service team raises the

question of credibility and credentialing of service providers within communities of color. Credibility bestowed from the dominant culture has value within communities of color only when the individual with such credentials is further vetted inside the community. This is typified by the concepts of *respeto*, *personalismo*, and *dignidad*, and *confianza* within Hispanic/Latino communities-concepts that dictate respect based on personhood rather than financial or occupational status (Soriana, 1995). Credibility in communities of color is more likely to be bestowed upon those with nonjudgmental attitudes, knowledge of the culture and demonstrated resourcefulness and effectiveness (Sue & Sue, 1999).

Credibility as a healer inside communities of color requires two things: *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. 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 living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships and performance within the community. RM models capitalize on such experiential expertise by recruiting indigenous healers as legitimate members of recovery management teams, e.g., outreach workers, recovery coaches, and culturally-grounded therapists/nurses/physicians.

RM also turns those seeking help into sources of support for others via their involvement in mutual support groups, peer-based service models and recovery advocacy organizations. Within communities of color, there is a long history of the concept of "wounded healer" (the idea that surviving a life-threatening illness or experience bestows knowledge and an obligation to help others facing this illness or experience), and a tradition of helpers credentialed by "calling" (White, 2000b). By transforming the process of recovery from an interaction between a professional and a patient to reciprocal support among members of a community of recovering and recovered people, RM taps this wounded healer tradition and utilizes what has been christened the "helper therapy principle" (the therapeutic effects of helping others) (Reissman, 1990, 1965). Converting service recipients into service dispensers exponentially expands indigenous recovery resources within communities of color. Reaching out to the suffering alcoholic/addict has been espoused by leaders of American recovery communities, from the Washingtonian mantra, "You've been saved, now save another" (White, 1998) to what Malcolm X referred to as "fishing for the dead" (Myers, 1993, p. 82). With its emphasis on transforming people who have been part of the problem into part of the solution, RM creates a cadre of people whose living example and recovery advocacy activities can help neutralize the particularly intense stigma that has long been attached to addiction in communities of color.

## People of Color and the Criminal Justice and Child Welfare Systems

People of color, particularly African Americans, are over-represented within America's criminal justice and child welfare systems. Constituting only 12.1% of the U.S. population (U.S. Census Bureau, 2000) and 15% of illicit drug consumers (SAMHSA, 1998), African Americans constitute 56.7% of those currently in state prison on drug offenses (Harrison & Beck, 2003). Studies

have also shown that race plays an important role in involvement in child protection services. Although rates of drug use during pregnancy are nearly identical for African American and White women, African American women are ten times more likely to be reported to child protection authorities for prenatal drug exposure (Neuspiel, 1996; Chasnoff, Landress, & Barret, 1990). Any intervention into alcohol and other drug problems in communities of color must recognize the dominant role of the criminal justice and child welfare systems as treatment referral sources.

The AC model of intervention is strongly linked to these systems and that is itself a problem. People of color with high problem severity and complexity continue to be routinely placed in brief interventions that have little chance of success and then are punished (via incarceration or loss of custody of children) on the grounds that "they had their chance" when those likely outcomes occur. The financially motivated collaboration of the treatment system in this process is altering the perception of treatment institutions from institutions of service and care to institutions of coercion and control. Masked behind euphemisms such as "treatment works" is the story of how addiction treatment programs have become an extension of the criminal justice and child protection systems within communities of color. We would argue that it is not enough to deflect people of color into treatment as an alternative to incarceration or family disintegration. The treatment received must be designed in such a way as to offer a realistic chance of success. Punishing people with high problem severity for failing to achieve sustained abstinence following treatment within an AC model is part of a long history of "blaming the victim" within communities of color.

It remains to be seen whether RM models will offer a more viable option for people of color involved in the criminal justice and child welfare systems, but RM models do have several characteristics that make success more likely. First, the longer duration of service contact in the RM model is more realistic and constitutes more of a real "chance" than treatment based on the AC model. The RM emphasis on engagement and sustained monitoring and support is very congruent with such criminal justice initiatives as intensive probation, drug courts and sentencing circles. It is also congruent with the gender-specific addiction treatment models emerging within the child welfare system (White, Woll, and Webber, 2003). More effective systems of intervention and support could decrease the number of people entering, and widen the doorways of exit from, the criminal justice and child protection systems.

**Expanded Menu of Services and Catalytic Metaphors**

*Metaphors are culturally-grounded figures of speech that in their subtlety, complexity and power strike deep emotional cords that ignite processes of personal transformation.* --White & Chaney, 1993

*…transformations of the self and its relationship to core symbols in a particular cultural system of meaning appear to lie at the heart of how people are restored to wholeness following their problematic involvements with alcohol.* --Spicer, 2001

The AC model of addiction treatment is based on the development of "programs" (a prescribed combination and sequence of therapeutic activities) that clients experience with minimal variation. Program activities and protocol focus on detoxification, problem stabilization and recovery initiation. RM models, by placing equal or greater emphasis on pre-treatment engagement and posttreatment recovery maintenance, expand the service menu considerably. The RM service menu is based on three premises:

1) People with AOD problems represent multiple clinical subpopulations with diverse needs: the effectiveness of treatment and support services varies considerably across clinical subpopulations and individuals within these subgroups.

2) There are developmental stages of long-term recovery: the same individual may need different treatment and support services at different stages of his or her addiction and recovery careers.
3) There are qualitative differences between AOD problems and the processes used in their resolution within communities of color.

RM replaces the treatment "program" with a large menu of service and support activities that are uniquely combined and supplemented to meet the stage-dependent needs of people in recovery. In this model, the service menu is constructed using frameworks of healing drawn first from the client's own cultural background, e.g., the use of specialized therapies such as the Japanese psychotherapeutic approach known as *Naikan* where the patient is sequestered for self-reflection on his or her character and relationships under the guidance of periodic visits from the therapist (*sinsei*) (Das, 1987). RM seeks to initiate and sustain recovery within the framework of cultural values using methods that markedly differ from client to client (Flores, 1985-86). The shift toward a multicultural menu of values and service activities requires a high degree of individualization and knowledge of the personal, intracultural and transcultural processes of long-term recovery.

RM proponents are also interested in the kinds of words, ideas, metaphors, and rituals that initiate and strengthen recovery, mark the shift from one stage of recovery to the next, and sustain recovery over a prolonged period of time. This interest is congruent with the belief in the power of words (speeches, sermons and stories) and healing ceremonies within communities of color. The following assumptions describe the potential role of words, ideas, metaphors and rituals in the addiction recovery process.

1) Words, ideas, metaphors and rituals can exert an enslaving or liberating effect on one's relationships with alcohol and other drugs (White and Chaney, 1993; White, 1996).
2) Words, ideas, metaphors and rituals that serve as a catalyst for change in one person or cultural group may have no such power with other persons or cultural groups. There are specific ethnic/cultural worldviews and the elements of these worldviews constitute the raw materials from which pathways of resilience to and recovery for AOD problems must be constructed (Taylor, 1992).
3) Catalytic metaphors[2] evolve and recycle within cultures over time. Their use as agents of transformation rests on their contemporary power; they must resonate within the present cultural and personal experience of the individual seeking recovery.
4) The growing phenomenon of biculturalism suggests that individuals may be able to combine or sequence metaphors from two or more cultures to initiate recovery or shift from one stage of recovery to the next.
5) Addiction treatment programs serving heterogeneous populations must provide a diverse menu of organizing words, ideas, metaphors and rituals to widen the doorways of entry into recovery and support culturally-mediated stages of long-term recovery (White, 1996).

The following observations reflect the ways in which words, ideas, metaphors and rituals have been used by historically disempowered peoples to initiate and sustain recovery from addiction.

1) During the peak period of contact and colonization, people of color are prohibited from drinking or provided only controlled opportunities for drinking (e.g., Slave Code prohibitions on drinking, Federal prohibition of the sale of alcohol to

[2] 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.

American Indians) and are targeted via drug prohibition laws (e.g., anti-opium ordinances aimed at Chinese immigrants, anti-cocaine laws aimed at African Americans, anti-peyote laws aimed at American Indians, and anti-marihuana laws aimed at Mexican immigrants) (Musto, 1973; Helmer, 1975; Morgan, 1983).
2) Patterns of psychoactive drug use and their effects upon people of color are exaggerated or fabricated as part of a racial mythology that justifies colonization and cultural domination (e.g., Native American "firewater
3) myths") (Coyhis & White, 2006; Morgan, 1983)
4) People of color, in their early struggles for liberation, use the consumption of alcohol and other drugs to cope with feelings of hopelessness and to deal with historical trauma.
5) Political and religious leaders within communities of color subsequently link AOD use to historical oppression, portray alcohol and other drugs as weapons of continued colonization and domination of their communities (Tabor, 1970; Herd, 1985), and portray sobriety as an act of resistance and liberation (Douglas, 1855; Cheagle, 1969).
6) Recovery mutual aid movements arising out of historically disempowered people emphasize metaphors of resistance, emancipation, and power, e.g., "I have a problem that once had me" (Kirkpatrick, 1986), "I will take control of my life" (Williams & Laird, 1992).
7) Heightened consciousness of racial history and identity can be a pathway of entry into recovery, or it can be part of a process of discovery in the later stages of recovery (Green, 1995).

The RM model embraces and works within these alternative frameworks of recovery. The viability of a particular metaphor for understanding AOD problems and how they can be resolved varies widely between cultures and varies degree of acculturation. The question is not: Which explanatory metaphor is true? The question is: Which organizing metaphor, by explaining things that are otherwise inexplicable, serves as a catalyst for personal, family and community healing. There are many people of color who have found recovery through mainstream treatment and recovery support organizations (e.g., AA/NA), but there are also many people of color who have recovered from addictions who do not portray themselves as having suffered from the *disease* of *alcoholism / addiction* nor portray themselves today as *alcoholics* or *addicts* in *recovery*. They have found alternative rationales for sobriety and different metaphors to explain who they once were and who they are today (Spicer, 2001). The goal of RM is not to impose an organizing metaphor for recovery, but to work within whatever metaphors individuals and families find most personally and culturally meaningful.

**Sustained Monitoring and Support**

*Chronic diseases require chronic cures.* --Kain, 1828

*If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients.* --McLellan, 2002

Communities of color have become distrustful of promised quick fixes because so many of those promises have been betrayed. Professionals come and go; programs come and go; agencies come and go. Arguments over whether addiction treatment should consist of five sessions or 25 sessions, five days or 30 days, cognitive or family therapy are all arguments inside the acute care model of admission, treatment, and discharge. The inherent brevity of acute interventions into complex, chronic problems is often experienced as superficial pacification, professional disinterest, exploitation and abandonment. People of

color, who tend to enter addiction treatment at later stages of problem severity and a greater number of co-occurring problems (Bell, 2002), are ill-served by service models whose low intensity and short duration offer little opportunity for success. At a practical level, the acute model provides few options: regular readmission for detoxification and respite, demoralization and a cessation of treatment-seeking, or a search for recovery maintenance outside the realm of professionally-directed treatment.

Communities of color need stable recovery support institutions that can move beyond brief experiments in recovery initiation toward prolonged recovery maintenance. It is this very need that has contributed to the dramatic growth of AA, NA and recovery-focused ministries in communities of color. For those who need sustained professional support, RM provides a culturally viable model of addiction treatment that replaces crisis intervention with a much longer, but lower-intensity, continuum of pre-treatment, in-treatment, and post-treatment recovery support services.

## A Recovery Management Partnership

*Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work.* --Albert Schweitzer**,** From *Reverence for Life*, 1993

The service relationship within acute care approaches to addiction treatment is based on an "expert" model of problem intervention. In this model, the service professional is assumed to have considerable knowledge, resources and power while the service recipient is assumed to suffer from one or more problems that he or she does not understand and cannot resolve. The role of the expert is to diagnose the problem, treat the problem and briefly educate the client regarding his or her continued self-care responsibilities related to the problem. Failure to resolve the problem is usually attributed to the lack of "patient compliance" with the expert's recommendations. The service relationship within the AC model of intervention, whether in the form of an emergency room visit for a broken bone or brief addiction treatment, is hierarchical, transient and commercialized. It reflects what Eisler (1987) has christened the "dominator model" of interpersonal relationships.

The historical victimization and abandonment of people of color have left a legacy of mistrust and caution when approaching relationships characterized by high discrepancies of power and brevity of contact. Given this legacy, developing trust in service relationships with people of color requires testing and time, and time is the one commodity the AC model, by definition, cannot provide.

RM models provide an alternative by providing continuity of contact in a sustained service relationship, shifting the nature of that relationship from one based on hierarchy to one based on a recovery management partnership, and incorporating support relationships (e.g., with volunteer recovery coaches) that are natural (reciprocal) and non-commercialized. In the RM partnership, it is assumed that strengths and weaknesses exist on both sides of the relationship, and that there is no universally effective professional intervention for severe AOD problems. Where the expert model is based on a teacher-student relationship, the partnership model assumes that learning will be mutual within the service relationship. A number of recovery initiation and maintenance strategies are co-developed and tried within the partnership relationship until the most effective strategy is found. Continuity of contact over time is crucial to the RM model, making the issue of high staff turnover a potential Achilles heel of the RM model.

A second Achilles heel of the RM partnership model is the danger that it could evolve into patterns of prolonged dependency that already exist in the AC model. Cultivating professional dependence and creating "system-sophisticated" clients that know how to "do treatment" and manipulate resources to sustain active

addiction is counterproductive and constitutes another form of colonization (using such clients as a cash crop to run the institutional economies of service industries and sustain the careers of service professionals). The goal of RM is a habilitation process that replaces dependency on formal service systems with interdependency within a larger social and cultural community. The essential principle is that professionally-directed services are the last, not the first, line of response to AOD problems and that professionally-delivered RM services should provide only what cannot be provided within the larger network of family and indigenous community supports.

RM models may also force agencies to redefine their institutional identities from one of a service-oriented business to a member of multiple communities of recovery—memberships that bring their own demands for accountability related to competence, consistency and continuity of access. Providing continuity of support and defining oneself in terms of personal and institutional membership in local communities of recovery are much more congruent with the natural patterns of helping within communities of color than are the "expert" or "business" models of delivering acute addiction treatment services.

## Culturally-nuanced Research and Evaluation

*Indian communities recognize all too well that the research process can be intrusive and the results invidious, divisive, and scandalous*. --Beauvais and Trimble, 1992

*…attempts to evaluate service program must have a dual acceptability; that is, they must be acceptable to the rigors of scientific exploration as well as the African-American ethos and worldview.* –Butler, 1992

Both the acute model and recovery management model aspire to be evidence-based, but the former is based primarily on short-term scientific studies of the efficacy (what works under ideal conditions) and effectiveness (what works under real conditions) of a single episode of brief intervention (McLellan, 2002). The first change within the RM approach to research and evaluation is to extend the time frame under which judgments of efficacy and effectiveness are rendered (White, Boyle & Loveland, 2002). Evidence that short-term effects of intervention (e.g., brief periods of sobriety) predict later therapeutic outcomes (e.g. sustained recovery) (see Weisner, et al, 2003) tells only part of the story. Time-related deterioration of effects, delayed positive effects and delayed iatrogenic (harmful) effects of service interventions can only be identified via longitudinal studies. It is also possible that multiple interventions into chronic disorders may have cumulative or synergistic effects (from particular service combinations and sequences) not identifiable through the evaluation of a single service episode.

Because RM is based on a long-term health management partnership with individuals, families and communities, it calls for a heightened level of sensitivity to constituency attitudes toward scientific research. In communities of color, researchers encounter two significant issues: 1) the distrust of culturally dominant research, and 2) different ways of knowing.

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 Americans 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 (Westermeyer, 1974; Leland, 1976) to the myth of racial invulnerability of Asians (O'Hare and Tran, 1998). 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 (See Frank, Augustyn, Knight, et al, 2001). They have been shamed by research designs and interpretations that dramatized the problems within communities of color while ignoring their strengths and resiliencies (Coyhis & White, 2002). Observers from within ethnic communities (Casas, 1992) 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.

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 (Hermes, 1998). It will require plotting the long-term pathways of addiction recovery in communities of color. It will require coming to grips with different ways in which communities of color determine what is true and what works in the addiction recovery arena. Most significantly, it will shift ultimate ownership of research from academic and funding institutions to the community being studied.

*Scientific knowledge* assumes that truth can be discovered through professional observation and the rational analysis of findings from controlled experiments. It is predicated on distance and objectivity (knowledge from outside) and is judged to exist only when it has been documented in writing, subjected to professional peer review, and independently replicated. There are two other ways of knowing within communities of color, and these exist more in oral tradition than in written words. The first, historical/cultural truth, asks, "What has been our past experience on this issue?" Racial memory is an important source of knowledge in communities of color—a source that seems alien to the highly individualist values and "now" orientation of the dominant American culture. Within communities of color, community elders rather than scientists are the ultimate authorities.

The second way of knowing, *experiential knowledge*, is based on the contemporary experiences of individuals, kinship networks and fellow community members. This way of knowing tends to be concrete, pragmatic, holistic, and commonsensical (Borkman, 1976). Word-of-mouth knowledge, captured in the collective stories of a community or a people, constitutes a key source of truth in communities of color. Communities of color do not reject science as much as require that its findings be filtered through the sieve of personal and community experience. In contrast to scientific knowledge, this way of knowing assumes that truth can only be discovered through proximity and experience (knowledge from inside). Living stories (experiential authority) have more power and cultural credibility than statistics (professional/scientific authority) within many communities of color. Living stories are best viewed as a unique and legitimate type of evidence rather than "myths" or "folklore" (Hermes, 1998). This does not mean that the usual methods of scientific analysis are abandoned, but that voices of the community are allowed to directly reach those who hear and read about the community through the medium of scientific research.

RM models will be required to pass the litmus test of multiple ways of knowing if they are to achieve credibility within and outside communities of color. The development of evidence-based services is a fundamental tenet of RM, but in communities of color the nature of that evidence will have to be broadened via qualitative studies that capture the historical and contemporary experience within communities of color. RM models in communities of color will also have to shift from an exclusively academic to a more activist orientation (studying questions of importance to the community, focusing on

knowledge that can facilitate positive personal, family and community change); enter into a research partnership with the community (e.g., control over design, conduct, interpretation and dissemination), and respect the community's ownership of its own knowledge.

**A Recovery Management Agenda**

This paper has contrasted acute care (AC) and recovery management models (RM) models of intervention into serious AOD problems. It is suggested that RM models offer advantages to communities of color in eight specific areas:

- an ecological perspective on the etiology of AOD problems
- a broadened target of intervention (including families, kinship networks and communities)
- a proactive, hope-based model of service engagement
- the inclusion of indigenous healers and institutions
- an expanded menu of culturally-grounded recovery support services and catalytic metaphors
- an extended time-frame of recovery support
- a partnership-based service relationship, and
- a culturally-nuanced approach to research and evaluation.

The reader may ask, "Where are these models of recovery management?" There may not be any treatment organizations that have fully developed all of the elements of RM described in this paper. RM exists as an emerging model whose service elements are currently being piloted and evaluated. The RM model is being utilized to transform whole behavioral health systems, e.g., the State of Connecticut and the City of Philadelphia. It exists within progressive treatment programs that are experimenting with new approaches to pre-treatment engagement and post-treatment continuing care. The model exists within the growing number of experiments with peer-based recovery support services. It exists within the growing network of peer-managed recovery homes in the United States. And perhaps most significantly, ts potential is demonstrated in the growing number of recovery-focused religious and cultural revitalization movements within American communities of color. The challenge is to create connecting tissue between treatment and recovery by building bridges between these indigenous recovery movements and addiction treatment institutions. RM holds great promise in communities of color, but fulfillment of that promise hinges on:

1.) involving clients, families and service professionals from within communities of color in the process of shifting existing interventions from AC models to locally designed, operated and evaluated RM models
2.) developing recovery management teams and advocacy coalitions via the integration of AOD service providers and indigenous institutions
3.) confronting forces in the community that promote excessive AOD use,
4.) enhancing "community recovery capital" (Granfield and Cloud, 1999)
5.) increasing the presence and visibility of indigenous sobriety-based support structures
6.) providing recovery education within communities of color, and
7.) using recovery role models that illustrate the viability and variety of recovery pathways within communities of color.

Achieving that vision will require that the field of addiction treatment fundamentally redefine the sources and solutions to AOD problems and, in the process, redefine itself.

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# RECOVERY MANAGEMENT AND RECOVERY-ORIENTED SYSTEMS OF CARE:

## SCIENTIFIC RATIONALE AND PROMISING PRACTICES

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# Prologue

This monograph, by William White, is sure to be regarded as a seminal work in the addictions treatment literature, as it is the first and most comprehensive attempt to lay out the empirical support for moving to recovery-oriented systems of care.

As White points out, the addictions treatment field is reaching a tipping point that is revolutionizing the ways in which behavioral health leaders think about people with alcohol and other drug problems, and consequently how services and systems are developed. At its core, this movement represents a shift away from a crisis-oriented, professionally directed, acute-care approach with its emphasis on isolated treatment episodes, to a recovery management approach that provides long-term supports and recognizes the many pathways to healing. This is what has been missing from the field—a systematic review of the literature to support this transition and the concrete strategies that will help make the vision of recovery-oriented service systems a reality.

White points out that, based on the scientific literature, the field must make radical changes in how treatment services are delivered. Indeed, there have been calls from government officials, treatment providers, and the advocacy community to transform systems of care based on the principles of recovery management. The challenge has been, however, that based on our science we know a lot about addiction but considerably less about recovery and how people recover. Despite this knowledge gap, many practitioners, program administrators, policy makers, and advocates have been actively engaged in trying to align their systems of care with the principles of recovery management. This work to-date has been guided more by values, beliefs, and theory than by empirical evidence. In this monograph, White masterfully weaves the latest research into a recovery management framework and gives the reader the science to understand and support the key principles of this framework.

In order to successfully implement the sweeping changes that are being called for, a clear understanding of recovery and recovery-oriented systems of care is essential. The term “recovery” has been used widely in the addictions field, resulting in many professionals’ assuming that they have been practicing recovery-oriented care. White, however, defines what is really meant by “recovery-oriented care” based on our clinical and scientific understanding of addiction. He goes on to challenge us to align our service delivery with the reality of recovery. This understanding is the first and most critical step in developing services and systems of care that are guided by a recovery vision.

With increasing calls for public accountability, this monograph will be a particularly invaluable resource for policy makers. Having the empirical support for the changes that are being pursued will be helpful to those who have to justify their actions to a legislature, a governmental chief executive, or the broader public.

Furthermore, to effectively move large systems of care from an acute-care model to a recovery management model is a Herculean task. To-date, a major challenge that policy makers and system administrators have faced in doing this work is the absence of a framework that could be used to guide their planning and understanding of the key issues that must be addressed.

While there has been growing consensus in the field that addictions treatment must be radically transformed around the principles of recovery management, with this monograph the field finally has the scientific ammunition to boldly carry out this important work.

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# Introduction and Acknowledgments

The modern field of addiction treatment was built on a foundation of assumptions, best guesses, and experiential knowledge. Distinctly missing were large, well designed, multi-site prospective studies that evaluated the effectiveness of treatment. Through its pre-professional developmental years (1945-1975), the fledgling field could not empirically answer crucial questions regarding the effectiveness of treatment as a system of care or the effectiveness of particular approaches to treatment. That status has dramatically changed.

Rigorous studies of addiction treatment have been completed in the United States and the United Kingdom. Some of the most notable of these include the:

- Drug Abuse Reporting Program (DARP) in the 1970s[1]
- Treatment Outcomes Prospective Study (TOPS) in the 1980s[2]
- Drug Abuse Treatment Outcome Study (DATOS) in the early 1990s[3]
- Drug Abuse Treatment Outcome Study for Adolescents in the early 1990s (DATOS-A)[4]
- National Treatment Improvement Evaluation Study (NTIES) in the early 1990s[5]
- California Drug and Alcohol Treatment Assessment (CALDATA) in the early 1990s[6]
- Project MATCH Experiments in the 1990s[7]
- Collaborative Cocaine Treatment (CCT) Experiments in the 1990s[8]
- National Treatment Outcome Research Study (NTORS) in the late 1990s[9]
- Marijuana Treatment Project (MTP) Experiments in the late 1990s[10]
- Methamphetamine Treatment Project (MTP) Experiments in the late 1990s[11]
- Cannabis Youth Treatment (CYT) Experiments in the late 1990s[12]
- Criminal Justice Drug Abuse Treatment Studies (CJDATS) in the 2000s (http://www.cjdats.org/ )
- NIDA Clinical Trials Network (CTN) in the 2000s (http://www.nida.nih.gov/CTN/)

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4. Hser, Y.I., Grella, C.E., Hubbard, R.L., Hsieh, S., Fletcher, B.W., Brown, B.S., & Anglin, M.D. (2001). An evaluation of drug treatments for adolescents in 4 US cities. *Archives of General Psychiatry*, *58*, 689-695.

5. Koenig, L., Denmead, G., Nguyen, R., Harrison, M., & Harwood, H. (1999). *The cost and benefits of substance abuse treatment: Findings from the National Treatment Improvement Evaluation Study (NTIES)*. Rockville, MD: Center for Substance Abuse Treatment.

6. Gerstein, D., Johnston, R., Harwood, H., Fountain, D., Suter, N., & Mallory, K. (1994, April). *Evaluating recovery services: The California drug and alcohol treatment assessment: General report.* Chicago, IL: National Opinion Research Center.

7. Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

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9. Gossop, M., Marsden, J., Stewart, D., & Kidd, T. (2003). The National Treatment Outcomes Research Study (NTORS): 4-5 year follow-up results. *Addiction*, *98*, 291-303.

10. Stephens, R.S., Babor, T.F., Kadden, R., & Miller, M. (2002). The Marijuana Treatment Project: Rationale, design and participant characteristics. *Addiction*, *97*(Suppl 1), 109-124.

11. Rawson, R.A., McCann, M.J., Huber, A., Marinelli-Casey, P., & Williams, L. (2000). Moving research into community settings in the CSAT methamphetamine treatment project: The coordinating center perspective. *Journal of Psychoactive Drugs*, *32*(2), 201-208.

12. 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.

- Pathways to Recovery 9-year Study from the 1990s to 2000s[13]
- Assertive Continuing Care (ACC) Experiments in the 1990s and 2000s[14]
- Early Re-Intervention (ERI) Experiments in the 2000s[15]

Broad population surveys such as the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) and the National Survey on Drug Use & Health (formerly called the National Household Survey on Drug Abuse, NHSDA) and longitudinal studies of alcohol and other drug (AOD) problems among community populations[16] have also helped chart the long-term course of AOD problems and their styles of resolution.

The development of national data-collection systems added to this knowledge by providing aggregate clinical and systems-performance data for publicly funded addiction treatment. These valuable sources of information included the Client-Oriented Data Acquisition Process (CODAP) and the Treatment Episode Data Set (TEDS), as well as periodic treatment system surveys such as the National Drug and Alcoholism Treatment Unit Survey (NDATUS), the Drug Services Research Survey (DSRS), the Services Research Outcomes Study (SROS), and the Alcohol and Drug Services Study (ADSS).

Many questions have yet to be answered, but today we can draw empirically grounded conclusions about the performance of addiction treatment as a system of care and the relationship between particular treatment approaches and long-term recovery. Based on a review of this growing body of data, a number of long-tenured observers of modern addiction treatment are setting forth a most provocative argument: Significantly improving long-term recovery outcomes will require a radical reengineering of addiction treatment as a system of care. Rather than system refinement, they are advocating a "fundamental shift in thinking,"[17] a "paradigm shift,"[18] a "fundamental redesign,"[19] a "seismic shift rather than a mere tinkering,"[20] and a "sea change in the culture of addiction service delivery."[21]

What is prompting such rhetoric? What changes in service philosophy and design are being proposed and tested? What scientific findings and systems-performance benchmark data underlie these calls for "systems transformation" and the push for "recovery-oriented systems of care"? The purpose of this monograph is to answer these and related questions.

---

13. 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; 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.

14. 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. (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.

15. 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. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55; 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*(Suppl 1), S63-S72.

16. Vaillant, G.E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051.

17. Moos, R.H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, *17*, 3-12.

18. 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*(Suppl 1), S51-S62.

19. White, W. (2005a). Recovery management: What if we <u>really</u> believed that addiction was a chronic disorder*? GLATTC Bulletin*, September, 1-8. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

20. Humphreys, K. (2006a). Closing remarks: Swimming to the horizon—reflections on a special series. *Addiction*, *101*, 1238-1240.

21. Miller, W.R. (2007). Bring addiction treatment out of the closet. *Addiction*, *102*, 863-869.

The material presented here defines and distinguishes two quite different models of addiction treatment: an acute-care (AC) model that focuses on brief biopsychosocial stabilization and a recovery management (RM) model that emphasizes sustained recovery support. The historical tension between these models is reaching a tipping point, and the stakes involved in the outcome are quite high.[22] As a professional field, we have oversold what a single episode of acute care can achieve for the more than two million individuals who each year enter the more than 13,000 specialty-sector addiction treatment programs in the United States. As a result, we are vulnerable to a backlash of cultural pessimism that might threaten the future of addiction treatment in America. Disillusioned service consumers and their families, allied professionals, policy makers, public and private purchasers of care, and a public weary of celebrities fleeing back to "rehab" following their latest public indiscretions might collectively revoke the probationary status under which modern addiction treatment has operated as a social institution for five decades. As we approach or surpass the point at which nearly everyone in the culture knows someone personally for whom addiction treatment did not "work," the task we embark on in these pages could not have greater import.

This monograph is written for those on the frontlines of addiction treatment. It is written for the addition service professionals, the clinical supervisors, and the clinical and administrative directors whose daily decisions widen or narrow the doorways of entry to long-term recovery for those they serve. You are being asked in this monograph to take a searching and fearless professional inventory of addiction treatment as currently practiced by yourself and others.

This monograph is also written to the policymakers, purchasers of care, monitors, and evaluators of addiction treatment. You are being asked to look at the scientific and system-performance data that support growing calls for "recovery-focused systems transformation" and to explore new approaches to funding and monitoring local addiction treatment programs.

This monograph is also written for the new generation of recovery advocates and recovery support specialists who are collectively calling for a reconnection between addiction treatment and the larger and more enduring process of addiction recovery.

This is the fifth in a series of monographs related to recovery management. The first, co-authored by William White, Dr. Ernest Kurtz, and Mark Sanders and published by the Great Lakes Addiction Technology Transfer Center in 2006, described the field's beginning shift toward a recovery paradigm, outlined the latest research on the varieties of recovery experience, and summarized

22. White, W.L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

the recovery management model and its particular relevance to communities of color. The second monograph, an edited consensus statement authored by Dr. Michael Flaherty and published by the Northeast Addiction Technology Transfer Center in 2006, was the product of an "addiction as chronic illness" advisory group whose members included Victor Capoccia, Dr. Mady Chalk, Dr. Herman Diesenhaus, Dr. Eric Goplerud, Rick Harwood, Dr. David Lewis, Dr. Tom McLellan, Dr. Kevin Mulvey, Dr. Rick Rawson, Dr. Ed Wagner, William White, and Dr. Mark Willenbring. The third monograph, co-authored by William White and Dr. Ernest Kurtz and published by the Northeast Addiction Technology Transfer Center in 2007, was a primer on how addiction professionals and recovery coaches can effectively link clients from addiction treatment to indigenous communities of recovery. The fourth monograph, published by Great Lakes ATTC in 2008, contained a series of interviews with persons on the forefront of developing "recovery-oriented systems of care," including Dr. H. Westley Clark, Dr. Tom Kirk, Dr. Arthur Evans, Mike Boyle, Phil Valentine, and Lonnetta Albright. Two forthcoming monographs will offer technical papers on the implementation of peer-based recovery support services and on treatment redesign within recovery-oriented systems of care.

The current monograph pauses to underscore the scientific rationale for addiction treatment systems transformation. This monograph:

- defines and distinguishes acute-care and recovery management models of addiction treatment,
- defines and distinguishes the terms *recovery management* and *recovery-oriented systems of care,*
- identifies recovery-focused performance measures (e.g., access, engagement, retention, service scope, service duration, linkage to communities of recovery, and post-treatment monitoring and support) that can be used to evaluate addiction treatment as a system of care and evaluate the performance of local organizations specializing in the treatment of severe AOD problems,
- presents findings from studies of addiction treatment and from national and state addiction treatment data collection systems related to the identified performance measures,
- highlights promising practices aimed at improving long-term recovery outcomes, and
- suggests measures that can be used to evaluate addiction treatment at both macro (system of care) and micro (individual program/unit/worker) levels of performance.

A brief note on the style of this monograph is warranted. First, this publication is a translation and interpretation of existing research, with a particular emphasis on implications for the design and delivery of addiction treatment and recovery support services. As such, extensive citations have been used to document the findings upon which conclusions and recommendations are drawn. Second, the monograph is intended to be widely read by addictions professionals and peer recovery support specialists. This aim dictated short, topically focused chapters and a writing style that was clear, direct, and as prescriptive as possible. It is hoped that the chapter summaries, topical headings and subheadings, bulleted lists, tables, and footnote system of referencing will make the information in this monograph highly accessible.

Synthesizing hundreds of published studies and commentaries would not have been possible without the sustained support of the Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health. I would like to acknowledge Lonnetta Albright, Mike Flaherty, and Arthur Evans for their sustained support of this project and the following individuals for their comments or discussions related to this paper: Mike Dennis, Felicia Dudek, Mike Flaherty, Mark Godley, Ken Ramsey, and Mark Sanders. Thanks also go to Jim Russell for his assistance in collecting data related to key treatment system performance indicators; to Chris Roberts and Barbara Weiner for assistance in procuring journal articles; and to Stephanie Guestchow, Diane Wuycheck, Debra Langer, and Pam Woll for their assistance with copyediting of the manuscript.

# Chapter One

## Modern Addiction Treatment: Emergence and Evolution of an Acute-Care Model

### ■ SUMMARY OF KEY POINTS ■

- Addiction (severe alcohol and drug dependency) shares many of the defining characteristics of chronic primary illnesses, e.g., 2 diabetes mellitus, hypertension, and asthma.
- Characterizing addiction as a *chronic* illness does not mean that all AOD problems have a prolonged course requiring professional treatment, that full recovery is not possible, or that self-management responsibilities are in any way diminished.
- Although long characterized as a chronic disorder, addiction has been treated in an essentially acute-care (AC) model of treatment.
- The AC model of addiction treatment is characterized by its crisis-linked point of intervention, brief duration, singular focus on symptom suppression (achievement of abstinence), professionally dominated decision-making process, short service relationship, and expectation of full and permanent problem resolution following "graduation."
- The development of the AC model of addiction treatment grew out of the medicalization, professionalization, and commercialization of addiction treatment and the subsequent growth of managed behavioral health care in the United States.

### Acute Versus Chronic Illnesses

Human beings throughout most of their history have died from illnesses and injuries whose course from onset to death was very short. Few achieved life expectancies long enough to die from the effects of a chronic illness. The early history of medicine constitutes a noble and highly successful battle against the roots of such acute illnesses. Eradicating many of these life-threatening illnesses left in its wake the emerging challenge of modern medicine-managing complex and costly chronic disorders over ever-increasing life expectancies. Treatment philosophies and approaches required to

effectively treat and manage these chronic conditions differ markedly from those that have long-guided acute medical interventions.[23]

The first challenge within today's medical interventions is to delineate the probable course of a presenting problem. This mandate is clear: "Acute, transient, self-limited conditions must be distinguished from those likely to be permanent or of lengthy duration."[24] A "chronic-care model" has been developed for the latter that empowers patients to take responsibility for self-monitoring and self-managing the long-term course of their conditions, with health care professionals serving as ongoing allies and consultants.[25]

## Addiction as a Chronic Disorder

Addiction has been conceptualized as a "chronic, progressive disease" for more than 200 years in the United States,[26] but the full implications of this proclamation have not been fully understood or reflected in clinical service protocols.

Chronic illnesses span a wide variety of human afflictions. Such disorders may be cellular (cancer), metabolic (diabetes, thyroid diseases), respiratory (asthma, chronic obstructive lung disease, emphysema, chronic bronchitis), cardiovascular (hypertension, atherosclerosis), vascular (migraine), hematological, (hemophilia, anemia), immunological (AIDS), autoimmunological (lupus, multiple sclerosis, rheumatoid arthritis), hepatic (Hepatitis C, cirrhosis), renal (chronic kidney disease), orthopedic (osteoporosis), gastrointestinal (Crohn's disease), neurological (epilepsy, Alzheimer's disease), psychiatric (schizophrenia), skin (psoriasis), or sensory (glaucoma, hearing loss), or involve such widespread conditions as allergies, sleep disorders, and chronic pain.

Severe alcohol and other drug dependencies share many characteristics with such chronic diseases, particularly with 2 diabetes mellitus, hypertension, and asthma. All of these conditions, including alcohol and drug dependence:

- are influenced by genetic heritability and other personal, family, and environmental risk factors;
- can be identified and diagnosed using well validated screening questionnaires and diagnostic checklists
- are influenced by behaviors that begin as voluntary choices but evolve into deeply ingrained patterns of behavior that, in the case of addiction, are further exacerbated by neurobiological changes in the brain that weaken volitional control over these contributing behaviors;

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23. 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.

24. Perrin, E. C., Newacheck, P., Pless, N., Drotar, D., Gortmaker, S. L., & Leventhal, J. et al. (1993). Issues involved in the definition and classification of chronic conditions. *Pediatrics*, *91*(4), 787-793.

25. Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence to practice. *Health Affairs*, *20*, 64-78; Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *Journal of the American Medical Association*, *288*, 2469-2474.

- are marked by patterns of onset that may be sudden or gradual;
- have a prolonged or permanent course that varies from person to person in intensity (mild to severe) and pattern (from constant to recurrent);
- are accompanied by risks of profound pathophysiology, disability, and premature death;
- have effective treatments, self-management protocols, peer support frameworks, and similar remission rates, but no known definitive cure;
- often generate psychological responses that include hopelessness, low self-esteem, anxiety, and depression; and
- generate excessive demands for adaptation by families and intimate social networks.[27]

Care must be taken in conceptualizing addiction as a chronic disorder, so that this does not constitute a professional euphemism for "Once a junkie, always a junkie."[28] Communications about addiction as a chronic disorder need to contain the following key elements.[29]

- *NOT all AOD problems are chronic—most do NOT have a prolonged and progressive course—but some do, and research is needed to identify early signs of chronic progression.*
- *NOT all persons with AOD problems need specialized, professional, long-term monitoring and support—many recover on their own and/or with family or peer support; again, research is needed to identify who is most likely to need intensive, professional care.*
- *Among those who do need treatment, relapse is NOT inevitable, and NOT all persons suffering from substance dependence require multiple treatments before they achieve stable, long-term recovery.*
- *Even with those who do relapse following treatment, families, friends, and employers should NOT abandon hope for recovery. (Community studies of recovery from alcohol dependence report long-term recovery rates approaching or exceeding 50%).[30]*
- *Having the serious chronic illness of addiction DOES NOT reduce personal responsibility for continuous efforts to manage that illness—just as those with serious diabetes or hypertensive disease must also manage their illnesses.*
- *Appropriate treatment for chronic addiction is NOT simply a succession of short-term detoxifications or treatment stays. Appropriate continuing care requires personal commitment to long-term change, dedication to self-management, and community and family support and monitoring.*

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26. White, W.L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems; White, W. (2000a). Addiction as a Disease: The Birth of a Concept. *Counselor, 1*(1), 46-51, 73.

27. 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; Roland, J.S. (1987). Chronic illness and the life cycle: A conceptual framework. *Family Process, 26*(2), 203-221.

28. DeLeon, G. (2004). Commentary on "Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy." *Journal of Substance Abuse Treatment, 26*, 163-165; Brown, B.S. (1998). Drug use: Chronic and relapsing or a treatable condition? *Substance Use and Misuse*, *33*(12), 2515-2520.

29. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor, 9*(3), 24-33.

30. 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.

- *Current addiction treatment outcomes are NOT acceptable simply because they are comparable to those achieved with other chronic disorders.*

## Defining the Acute-Care Model

In spite of rhetorical declarations about the "chronicity of addiction" and comparative studies between addiction and other chronic health problems, addiction continues to be treated in the United States and most countries of the world as if it were a bacterial infection, a broken bone, or a ruptured appendix. Modern addiction treatment in the United States is being delivered primarily through six modalities—inpatient or social setting detoxification, outpatient detoxification, short-term inpatient or residential treatment, long-term residential treatment (primarily in therapeutic communities or TCs), methadone maintenance treatment (MMT) and other medication-assisted opiate treatments, and outpatient drug-free treatment. These modalities encompass innumerable variations in philosophies, techniques, and service combinations, but all, including TCs and MMT, have been profoundly influenced by the broader acute-care model of addiction treatment.

In the major treatment modalities in the United States, services are delivered through federal programs, state and local government-operated programs, private not-for-profit programs, and private for-profit programs. There are differences in these programs by size, payor mix, service fees, client characteristics, staff credentials, staffing patterns, and scope of services offered,[31] but all utilize variations of the acute-care model of addiction treatment. Debates over the relative superiority of different modalities, ingredients of treatment, and ownership structures all tend to be conducted inside the same acute-care conceptual box.

The acute-care (AC) model of intervention that has dominated specialized addiction treatment since its inception in the mid-nineteenth century is distinguished by the following characteristics:

- Services are delivered "programmatically" in a uniform series of encapsulated activities (screening, admission, a single point-in-time assessment, a short course of minimally individualized treatment, discharge, and brief "aftercare" followed by termination of the service relationship).
- The intervention is focused on symptom elimination for a single primary problem.
- Professional experts direct and dominate the assessment, treatment planning, and service delivery decision-making.

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31. 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; Wheeler, J.R., & Nahra, T.A. (2000). Private and public ownership in outpatient substance abuse treatment: Do we have a two-tiered system? *Administration and Policy in Mental Health, 27*, 197–209; Wheeler, J.R.C., Fadel, H., & D'Aunno, T.A. (1992). Ownership and performance of outpatient substance abuse treatment centers. *American Journal of Public Health, 82*, 711-718.

- Services transpire over a short (and historically ever-shorter) period of time—usually as a function of a prearranged, time-limited insurance payment designed specifically for addiction disorders and "carved out" from general medical insurance.
- The individual/family/community is given the impression at discharge ("graduation") that "cure has occurred": long-term recovery is viewed as personally self-sustainable without ongoing professional assistance.
- The intervention is evaluated at a short-term, single-point-in-time follow-up that compares pre-treatment status with discharge status and post-treatment status, months—or at best a few years—following professional intervention.
- Post-treatment relapse and readmission are viewed as the failure (non-compliance) of the individual rather than possible flaws in the design or execution of the treatment protocol.[32]

Most important among these characteristics is that the current treatment of addiction, like treatment of acute illnesses, is time-limited with no prolonged professional monitoring, support, or strategic re-intervention. Today, addiction treatments, regardless of the number of days or sessions or theoretical orientation, have clearly marked beginnings, middles, and ends that constitute ever-shorter temporal boundaries of the service process and the service relationship. If severe AOD dependency was an acute phenomenon, this would be appropriate, but there are two uniform findings in outcome studies of addiction treatment across modalities: 1) "treatment effects decay over time"[33] and 2) long addiction and treatment careers often precede the achievement of sustainable recovery.[34]

Historically, the acute-care model sets the field up in ways that erode long-term cultural confidence in addiction treatment as a social institution:

> *One of the problems with the expectation of long-term change following a single episode of care is that it holds substance abuse treatment to a very high standard—one that is not imposed on treatments for most medical or behavioral disorders.*[35]

## Why an AC Model?

How did addiction treatment come to embrace an acute-care (AC) model of intervention? A confluence of circumstances contributed to the solidification of an AC model as the core design of modern addiction treatment during the 1970s and 1980s.

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32. White, W., & McLellan, A.T. (in press). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*.

33. Weisner, C., Delucchi, K., Matzger, H., & Schmidt, L. (2003). 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.

34. 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; 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.

35. O'Brien, C., & McLellan, A.T. (1996). Myths about the treatment of addiction. *Lancet, 347*, 237-240; McKay, J.R., & Weiss, R.V. (2001). A review of temporal effects and outcome predictors in substance abuse treatment studies with long-term follow-ups: Preliminary results and methodological issues. *Evaluation Review*, *25*, 113-161.

**THE MEDICALIZATION OF TREATMENT:** The desire to legitimize addiction treatment institutionally led to emulation of the field of primary medicine. Early accreditation standards for programs treating alcohol and drug dependence were adapted from standards for acute-care hospitals, with little focus on service support for long-term recovery. The emerging system of addiction treatment—prior to the funding backlash of the early 1990s—was focused on building bed capacity for acute biopsychosocial stabilization rather than building resources in the community to support long-term recovery maintenance. Ironically, addiction treatment modeled itself on the acute-care model of primary medicine at the exact time critics were documenting the ineffectiveness of this model for chronic primary health disorders.[36]

**CATEGORICAL SEGREGATION:** Addiction treatment became part of a categorically segregated health and human service system in the United States—a system marked by ever-increasing numbers of service silos that each focused on a specialized problem area. Such segregation prevented us from looking at the whole person and generating services to support the evolution of global (multidimensional) health in long-term recovery.

**PROFESSIONALIZATION OF ADDICTION COUNSELING:** Counselor credentialing (certification and licensing) movements modeled themselves on the short-term psychotherapy roles within the fields of psychology and social work. This raised the professional legitimacy of the counselor (from its earlier "paraprofessional" status) and elevated the counselor's role in recovery initiation, but left the service consumer abandoned in his or her efforts at post-treatment recovery maintenance.

**BUSINESS ORIENTATION:** The rapid shift in program orientation from a client-focused recovery orientation (1960s-1970s) to an institution-focused business orientation (1980s) diminished client advocacy and contributed to acceptance of an aggressive program of managed behavioral health care that shortened lengths of stay and eliminated continuing care as a reimbursable service. This process removed ultimate accountability for local addiction treatment programs from the individuals and families they served, and instead placed it on public and private purchasers of care; accrediting and monitoring authorities; and parental organizations, as programs were purchased or merged into larger organizational networks. In this transition the nature of accountability for local programs shifted from long-term recovery outcomes to regulatory compliance, procedural efficiency, and maximization of billable services.[37] Reviews of the effects of managed behavioral health care note a decrease in front-end access to addiction treatment; decreased intensity, scope, and magnitude of

36. 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. *Health Affairs*, *20*, 64-78.

37. White, W.L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

services delivered; and reduced service completion rates—factors that we shall see are all critical predictors of long-term recovery.[38]

**DISCONNECTION FROM COMMUNITIES OF RECOVERY:** There is a tendency for grassroots treatment programs closely connected to local communities of recovery to become professionalized, bureaucratized, and disconnected from these communities over time.[39] In the wake of the professionalization and commercialization of addiction treatment, the relationships between treatment institutions and indigenous communities of recovery were weakened or lost altogether. Such disconnection was evident in the reduced percentage of staff in recovery, abandonment of the expectation that all staff would participate in local recovery support meetings (e.g., open meetings of AA/NA and Al-Anon), cessation of meetings between the treatment center and the service committees of local recovery support fellowships, and the weakening or collapse of volunteer programs and alumni associations. Such disconnection contributed to the loss of focus on long-term recovery.

**LEVEL-OF-CARE SPECIALIZATION:** Over the course of two decades, clients in addiction treatment went from receiving a spectrum of services from a single provider to a level-of-care system in which detoxification, inpatient treatment, intensive outpatient treatment, and "aftercare" services were often provided by multiple organizations, with no organization maintaining continuity of contact and support over time. This division of labor defined responsibility for particular service sets, but left no one responsible for continual monitoring and support of the long-term recovery process.

**RECOVERY MAINTENANCE VERSUS RECOVERY INITIATION:** Factors that sustain recovery ("maintenance factors") are different from those factors that serve to initiate recovery ("triggering mechanisms").[40] Where treatment can play a critical role in recovery initiation, factors outside the treatment experience play a more critical role in long-term recovery maintenance,[41] and these factors become more important as time from treatment discharge increases.[42]

In the next chapter, we will look at the forces that are coming together to galvanize support for a major redesign of addiction treatment service models.

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38. Ghose, T. (2008). Organizational- and individual-level correlates of posttreatment substance use: A multilevel analysis. *Journal of Substance Abuse Treatment*, *34*, 249-262.

39. Lusky, R.A., & Ingman, S.R. (1979). The pros, cons and pitfalls of "self-help" rehabilitation programs. *Social Science & Medicine*, *13A*, 113-121; White, W. (2002a). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly, 19*(4), 1-32.

40. Humphreys, K., Moos, R.H., & Finney, J.W. (1995). Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*, *20*(4), 427-441.

41. Vaillant, G. (1983). *The natural history of alcoholism: Causes, patterns, and paths to recovery*. Cambridge, Massachusetts: Harvard University Press; Westermeyer, J. (1989). Nontreatment factors affecting treatment outcome in substance abuse. *American Journal of Drug and Alcohol Abuse*, *15*, 13-29; DeLeon, G., Melnick, G., Cao, Y., & Wexler, H. (2006). Recovery-oriented perceptions as predictors of reincarceration. *Journal of Substance Abuse Treatment*, *31*, 87-94.

42. Mann, K., Schafer, D.R., Langle, G., Ackermann, K, & Croissant, B. (2005). The long-term course of alcoholism, 5, 10, and 16 years after treatment. *Addiction*, *100*, 797-805.

# Chapter Two

## The Momentum for Change

### ■ SUMMARY OF KEY POINTS ■

- The AC model of specialized addiction treatment has measurable positive effects compared to the absence of intervention or the alternative use of non-specialized interventions, but these effects vary widely by program, counselor, and population served.
- Based on the growing body of outcome data, marketing of the AC model has oversold what individuals, families, and referral sources can expect from a single episode of brief, specialized treatment of severe AOD problems.
- Challenges to the AC model and calls for a more sustained recovery management (RM) model have come from multiple sources: a new grassroots recovery advocacy movement, disillusioned payors, research data on limitations of the AC model, positive evaluations of RM model components (e.g., recovery checkups), and excitement generated by recent "recovery-oriented systems-transformation" pilots, e.g., the State of Connecticut and the City of Philadelphia.
- "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.
- "Recovery management" (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality-of-life enhancement for individuals and families affected by severe substance use disorders.

## "Treatment Works," But...

It is hard to convey in words what the modern system of addiction treatment has meant to millions of individuals and families, as well as communities across the United States. Lives—including those of many who will read this monograph—have been saved and transformed. Families have been healed and restored. Individuals who once wounded their communities have been returned to those communities as assets whose service work has further extended the fruits of their recoveries. The blessings of this system of care have been summed up in recent years by the effusive slogan, "Treatment Works!"

This marketing mantra of addiction treatment has much to commend it, including its acknowledgement of the superiority over the institutions it replaced (e.g., "drunk tanks" in jails and "inebriate wards" of aging state psychiatric hospitals), its celebration of those whose recoveries have been initiated through the vehicle of treatment, and its honoring of those who work on the frontlines of addiction treatment. However, the slogan "treatment works" 1) erroneously suggests a homogenous set of services that are consistent in design and quality across the United States, 2) ignores pathways of recovery that do not involve treatment, 3) misrepresents the highly variable and complex outcomes of addiction treatment, 4) shifts the focus of recovery from the person seeking treatment to the treatment professional, and 5) conveys a mechanical quality of treatment analogous to taking antibiotics for a few weeks or having a tumor surgically removed.[43]

The acute-care model of specialized addiction treatment does "work" in the sense that it has measurable positive effects, compared to the absence of any intervention or the alternative use of non-specialized interventions.[44] This finding has been confirmed in multiple national studies in the United States and England.[45]

> *...treatment programs with diverse ideologies are effective in reducing substance use and improving psychosocial outcomes. These effective programs engage clients in a common focus, which is to help them understand, adapt to, and alter their life circumstances.*[46]

Post-treatment remissions average about one third, overall AOD use decreases by more than 80% in the months following discharge, and substance-related problems decrease by 60% in the months following treatment.[47] Treatment-influenced reductions in alcohol and other drug use are also linked to rapid reductions in illegal activity and illegal income,[48] as well as reduced risk of HIV and other addiction-related infectious diseases and health problems.[49]

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43. White, W. (2005c). Treatment Works: Is it time for a new slogan? (Abridged). *Addiction Professional*, *3*(1), 22-27.

44. Moos, R.H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, *17*, 3-12; 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.

45. Simpson, D.D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment*, *27*, 99-121.

46. Moos, R.H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, *17*, 3-12.

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48. Dismuke, C.E., French, M.T., Salome, H.J., Foss, M.A., Scott, C.K., & Dennis, M.L. (2004). Out of touch or on the money: Do the clinical objectives of addiction treatment coincide with economic evaluation results? *Journal of Substance Abuse Treatment, 27*(3), 253-63; Scott, C.K, Foss, M.A., Lurigio, A.J. & Dennis, M.L. (2003). Pathways to recovery after substance abuse treatment: Leaving a life of crime behind. *Evaluation and Program Planning, 26*(4), 403-12; 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.

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This good news about treatment-facilitated recovery even extends to those addicted to drug choices that have been portrayed in the popular press as particularly pernicious. A 12-year follow-up of persons treated for cocaine dependence found 52% in stable recovery,[50] and a follow-up of clients treated for methamphetamine dependence showed a recovery rate similar to those of clients treated for heroin or cocaine dependence.[51] But as we shall see in later chapters, the effect of treatment varies considerably from program to program, from counselor to counselor, and from client to client.

The positive evaluations of addiction treatment leave us with the question: Why do we need a fundamental change in the design of addiction treatment? This chapter will briefly outline the forces that set the stage for calls to transform the design of addiction treatment.

## The Coming of Age of American Communities of Recovery

Recovery mutual aid support groups have been conceptualized as an adjunct and "aftercare" arm of addiction treatment since the nineteenth century heydays of the Washingtonians, the sobriety-based fraternal temperance societies, the ribbon reform clubs, and institution-based support fellowships (e.g., the Keeley Leagues, the Godwin Association).[52] A fully developed culture of recovery is now emerging in America. The most significant of recent developments include:

- the growth and diversification (secular, spiritual, and religious) of recovery mutual aid societies;[53]
- the emergence of a new grassroots recovery advocacy movement in the United States;[54]
- the rise of recovery community organizations that exist independent of addiction treatment organizations and recovery mutual aid societies;[55] and
- the proliferation of new recovery community institutions, e.g., recovery homes, recovery colonies, recovery industries, recovery schools, recovery ministries/churches, peer-directed recovery support centers, and Internet-based recovery communities.[56]

The growth and maturation of this culture of recovery is forcing a reevaluation of the role of professional treatment and communities of recovery in the long-term recovery process.

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50. Hser, Y.I., Stark, M.A., Paredes, A., Huang, D., Anglin, M.D., & Rawson, R. (2006). A 12-year follow-up of a treated cocaine-dependent sample. *Journal of Substance Abuse Treatment*, *30*, 219-226; 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*, 507-514.

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53. Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions.* Cambridge: Cambridge University Press; White, W. (2004a). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538; Room, R. (1998). Mutual help movements for alcohol problems in an international perspective. *Addiction Research*, *6*, 131-145.

54. White, W. (2007a). The new recovery advocacy movement in America. *Addiction, 102,* 696-703; White, W., & Taylor, P. (2006). A new recovery advocacy movement. Posted at www.facesandvoicesofrecovery.org

55. 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

56. White, W. (in pressa). The culture of recovery in America: Recent developments and their significance. *Counselor.*

## Disillusionment among Purchasers of Addiction Treatment Services

The expansion of insurance coverage for alcoholism treatment in the 1970s and 1980s set the stage for the explosive growth of private, hospital-based, and freestanding addiction treatment programs in the United States throughout the 1980s. Abuses within the treatment industry (e.g., excessive fees, inappropriate admissions and readmissions, excessive lengths of stay, full charges for time patients spent on weekend passes, and unethical marketing practices) triggered a financial backlash and the emergence of an aggressive system of managed behavioral health care that produced a 20% fatality rate among private sector treatment facilities between 1989 and 1991[57] and the subsequent collapse of some of America's largest and best known treatment providers (e.g., Parkside).[58]

For programs that survived the 1990s, this backlash produced an overall decrease in private-pay expenditures for addiction treatment and instigated new service protocols, including provider selection by payors, standardized assessment instruments, patient placement criteria, evidence-based practice guidelines (and worker credentialing), and post-discharge follow-up, as well as new benefit limitations and greater administrative burdens, e.g., increased paperwork and phone negotiations related to service access and service continuation. The federal and state agencies that came to bear an increasing financial burden for addiction treatment implemented similar guidelines through new systems of public managed behavioral health care.[59] What became evident in both private and public treatment systems was the existence of a growing population of individuals with severe AOD problems who were recycling through repeated episodes of expensive acute-care treatment without evidence of long-term recovery outcomes. This triggered calls for a better model of addressing complex and chronic AOD problems.[60]

## Visions of a Transformed System of Care

Recognition of the repeated recycling of people through the acute-care model of addiction treatment spurred calls for a model of sustained recovery management more analogous to the management of other chronic health care problems.[61] Such approaches in primary medicine have been collectively christened the "chronic-care model".[62] In the arena of addiction treatment, this approach is reflected in such concepts as *extended case monitoring,*[63] *chronic care or disease management,*[64] *stepped care,*[65] *assertive continuing care*,[66] *recovery management*,[67] *recovery coaching*,[68] *post-treatment recovery support services*,[69] *recovery management checkups,*[70] *concurrent recovery monitoring*,[71] *adaptive treatment,*[72] and *sustained care.*[73]

57. Roman, P.M., Johnson, J.A., & Blum T.C. (2000). The transformation of private alcohol problem treatment: Results from a national study. *Advances in Medical Sociology, 7*, 321-342.

58. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

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64. McLellan, A.T., Lewis, D.C., OíBrien, 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.

65. Sobell, L.C., & Sobell, M.B. (2000). Stepped care as a heuristic approach to the treatment of alcohol problems. *Journal of Consulting and Clinical Psychology*, *68*, 573-579.

66. 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.

67. White, W., Boyle, M., & Loveland, D. (2003). Recovery management: Transcending the limitations of addiction treatment. *Behavioral Health Management, 23*(3), 38-44; White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management.* (Monograph). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

## Toward a Recovery Paradigm

Calls for a "chronic-care" model of addiction treatment grew out of and in turn intensified a shift in the organizing paradigm of the addictions field from one of pathology (focus on the etiology and patterns of AOD problems) and intervention (focus on professional-directed addiction treatment) to a focus on the lived solution (focus on long-term addiction recovery).[74] This emerging recovery paradigm is evident in calls to reconnect addiction treatment to the larger and more enduring process of addiction treatment,[75] and to growing scientific interest in AA, other Twelve Step programs, and secular and religious alternatives to Twelve Step programs.[76] At the treatment system level, it is also evident in:

- the emergence of recovery as an organizing fulcrum for national, state, and urban addiction treatment policy;[77]
- efforts to define recovery;[78]
- calls for a fully developed recovery research agenda;[79]
- federal programs promoting peer-based recovery support services, such as CSAT's Access to Recovery and Recovery Community Services Program; and
- calls to use recovery as an integrating bridge for the addiction and mental health fields.[80]

The field seems to be shifting its historical focus toward the processes of recovery initiation to pathways, patterns, stages, and styles of long-term recovery. That transition has opened the door for the concepts of *recovery management and recovery-oriented systems of care,* which are heard with increasing frequency but are often ill-defined or used interchangeably.[81]

Among mainstream addiction treatment representatives, advocacy of such redesign of addiction treatment is triggering fears that the crucial role treatment plays in recovery initiation for many people might be lost in this new focus on long-term support processes.[82] The author shares this concern and has tried to emphasize that models of sustained support are an extension of the acute-care model, not a call to eliminate resources for acute stabilization and recovery initiation. As with any chronic disorder, episodes of acute biopsychosocial stabilization are essential to save lives, and such episodes often play a critical role in the movement toward long-term recovery. The issue is not whether we have professionally directed addiction treatment or peer-based recovery support services, but how these and other supports can be best combined and sequenced to enhance long-term recovery outcomes.

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74. White, W. (2004). Recovery: The next frontier. *Counselor*, *5*(1), 18-21; White, W. (2005b). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15; 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.

75. Zweben, J.E. (1986). Recovery-oriented psychotherapy. *Journal of Substance Abuse Treatment*, *3*, 255-262; Zweben, J.E. (1997). Recovery-oriented psychotherapy: Facilitating the use of 12-Step programs. *Journal of Psychoactive Drugs*, *19*(3), 243-251; 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; Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery, 6*(2), 11-23; White, W. (2005b). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15; 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.

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## Recovery-oriented Systems of Care as a Macrosystem Organizing Philosophy

The phrase *recovery-oriented systems of care* as used in this monograph refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families 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.

## Recovery Management as a Microsystem Organizing Philosophy

*Recovery management* as used in this monograph 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.

As we shall see, achieving both a recovery-oriented system of care and the implementation of a recovery management philosophy requires substantial changes in treatment philosophies, purchase-of-care strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the roles of the service professional and service consumer, the training and supervision of staff and volunteers, and intra- and inter-organizational relationships.[83]

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79. Laudet, A.B. (2008). Building the science of recovery. Presented at the Recovery Symposium, May 1-2, Philadelphia, PA: Sponsored by the Institute for Research, Education and Training in Addictions.

80. 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; 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; 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.

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82. Huniscker, R. (2008). Another acronym to learn: ROSC. *NAATP Visions*, *May*,

83. Anthony, W.A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, *24*(2), 159-168; Kirk, T. (2007). Creating a recovery-oriented system of care. Retrieved on June 26, 2007, from htttp://www.glattc.org/Interview%20With%20Thomas%20A.%20Kirk,%20Jr.,%20PhD.pdf

# Chapter Three

## Recovery-focused System Performance Measures

### ■ SUMMARY OF KEY POINTS ■

- Interest is rapidly growing in the development of formal, systems-level performance measures for addiction treatment.
- Recovery-focused performance measures include three dimensions of systems evaluation: 1) measures of infrastructure stability and adaptive capacity, 2) recovery-focused service process measures, and 3) long-term recovery outcome measures.
- Infrastructure stability and adaptive capacity reflect the capacity of an organization to undergo systems-transformation processes (e.g., from an AC to an RM model of care) and the capacity of an organization to fulfill its commitment to continuity of contact and support over time for individuals and families seeking long-term recovery.
- Recovery-oriented service process measures (e.g., early identification, engagement, retention, etc.) are intermediary outcomes that are linked to the final goal of long-term individual and family recovery.
- Long-term recovery outcome measures represent the major fruits of recovery, defined here as the resolution of alcohol and other drug problems, the progressive achievement of global (physical, emotional, relational) health, and citizenship (life meaning and purpose, self-development, social stability, social contribution, and elimination of threats to public safety).

  *The attainment of recovery must be an integral part of all efforts to improve treatment quality, effectiveness and efficiency.—McLellan, Chalk & Bartlett*[84]

Addiction treatment outcomes are best viewed in systemic terms—achievements that are influenced by policy-level, community-level, program-level, and client-level variables.[85] There is an *ecology of addiction recovery* revealed through studies of the inter-relationships among individuals experiencing and resolving severe AOD problems and their physical, family, social, and cultural environments.[86] These ecological influences are graphically depicted below as adapted from Urie Brofenbrenner's ecological systems theory.

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84. McLellan, A.T., Chalk, M., & Bartlett, J. (2007). Outcomes, performance, and qualityóWhatís the difference? *Journal of Substance Abuse Treatment*, *32*, 331-340.

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**Figure 1: The Ecology of Recovery**

Addiction recovery within the Brofenbrenner framework is influenced by multiple levels of the recovering person's ecosystem.[87] At the center of this ecological onion rests the individual and the internal vulnerabilities and assets the individual brings to AOD problem-resolution efforts.

Embracing the individual is the microsystem—the immediate physical, family, social, and cultural environments that can act to inhibit or support AOD problem resolution. The microsystem can be thought of in terms of direct influence—one's family and kinship network, intimate and social relationships, the neighborhood, and the workplace that constitute one's stage of daily living.

The second layer of the environment is the mesosystem, conceptualized here as the professional services and indigenous recovery supports available to the individual. The mesosystem encompasses local addiction treatment resources as well as recovery supports available in the local community to support long-term recovery.

Brofenbrenner's third layer of the ecosystem is the exosystem—the larger community environment in which recovery efforts succeed or fail. Recovery-linked components of the exosystem include community attitudes about addiction/recovery, resource accessibility from the larger network of health and human services, and the response of key community institutions (law, religion, medicine, financial institutions, media, and business and industry) to those with AOD problems.

The broadest layer of the recovery environment is the macrosystem. The macrosystem encompasses broad state, national, and international trends that exert a profound influence on the recovery efforts of individuals, families, and local communities. The macrosystem includes broad AOD-related attitudes and policies as well as the more focused policies and programs of federal and state agencies and related support institutions in the addictions field (e.g., advocacy, research, and education and training).

Long-term addiction recovery is about more than a relationship between an individual and a treatment center; it is about altering the complex relationships between individuals and the multiple layers of the ecosystem in which individuals and families are nested. As such, all layers of this ecosystem are targets of recovery-focused interventions. Our particular focus in this monograph will be on those aspects of the mesosystem (treatment and recovery support structures and processes) and the family and community milieus that influence post-treatment recovery outcomes.[88]

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87. Berk, L. (2001). *Development through the lifespan*. Boston: Allyn & Bacon.

88. White, W. (in pressc). ¡With a Little Help from my Friendsî: The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.

## Systems Perspectives on Treatment Performance Measurement

Interest in performance and outcome measures for addiction treatment is growing in the United States.[89] Legislative oversight committees, independent policy groups, federal and state alcohol/drug agencies, addiction treatment program licensing and accreditation authorities, public and private purchasers of services, research institutions, and recovery advocacy organizations are all holding addiction treatment institutions to an increased level of accountability.[90] Varied and sometimes conflicting interests of these groups create multiple expectations of addiction treatment as a cultural institution. These interests span:

- access to care,
- achievement of personal recovery,
- reduction of threats to public health (e.g., AOD-related disease transmission),
- reductions in threats to public safety (e.g., AOD-related crime and violence, AOD-impaired driving),
- reductions in threats to the welfare of children (e.g., AOD-related child neglect and abuse),
- organizational prestige (of organizational leaders and institutional boards),
- institutional profit (e.g., for addiction treatment organizations), and the
- stewardship of public and private expenditures (e.g., purchasers of treatment services).[91]

All of these interests reflect legitimate goals, but the performance expected of addiction treatment institutions will vary widely depending on prioritization of these interests.

This monograph will focus on performance measures that directly affect the ability of addiction treatment as a specialized system of care to provide sustained support to individuals and families in **long-term** recovery from severe substance use disorders. In the following discussions, we will explore three critical performance arenas of addiction treatment as a system of care: 1) infrastructure stability and adaptive capacity, 2) recovery-focused service process measures, and 3) treatment/recovery outcomes. These broad arenas have figured prominently in work to-date conceptualizing treatment/recovery processes[92] and formulating performance measures for evaluating addiction treatment.[93] All three arenas are important, whether we are talking about the evaluation of a local treatment agency or the evaluation of addiction treatment as an American cultural institution.

89. Center for Substance Abuse Treatment. (1995). *Developing state outcomes monitoring for alcohol and drug abuse treatment*. Treatment Improvement Protocol (TIP) Series 14. DHHS Publication. Rockville, MD: Substance Abuse and Mental Health Services Administration; McCarty, D. (2007). Performance measurement for systems treating alcohol and drug use disorders. *Journal of Substance Abuse Treatment*, *33*, 353-354; Garnik, D.W., Horgan, C.M., Lee, M.T. Panas, L., Ritter, G.A., Davis, S., Leeper, T., Moore, R., & Reynolds, M. (2007). Are Washington Circle performance measures associated with decreased criminal activity following treatment? *Journal of Substance Abuse Treatment*, *33*, 341-352; Garnik, D.W., Lee, M.T., Chalk, M., Gastfriend, D., Horgan, C.M., McCorry, F., McLellan, A.T., & Merrick, E.L. (2002). Establishing the feasibility of performance measures for alcohol and other drugs. *Journal of Substance Abuse Treatment*, *23*, 375-385; Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2002). Year 2000 discharges by reason for discharge, according to type of service: TEDS 2000. (Number and percent distribution). Retrieved February 20, 2008, from http://wwwdasis.samhsa.gov/teds00/6.3a.htm; Soldz, M.J., Panas, L., & Rodriguez-Howard-Howard, M. (2002). The reliability of the Massachusetts Substance Abuse Management Information System. *Journal of Clinical Psychology*, *58*, 1057-1069.

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91. Wheeler, J.R.C., Fadel, H., & D'Aunno, T.A. (1992). Ownership and performance of outpatient substance abuse treatment centers. *American Journal of Public Health*, *82*, 711-718.

92. Simpson, D.D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment*, *27*, 99-121.

93. Pelletier, L.R., & Hoffman, J.A. (2001). New federal regulations for improving quality in opioid treatment programs. *Journal of Healthcare Quality*, *23*(2), 29-33; McLellan, A.T., Chalk, M., & Bartlett, J. (2007). Outcomes, performance, and quality—What's the difference? *Journal of Substance Abuse Treatment*, *32*, 331-340.

## Infrastructure Stability and Adaptive Capacity

Treatment outcomes are usually thought of as being determined by such client variables as problem severity or degree of motivation for change, but there is growing evidence that program and extra-program contextual factors exert significant influences on the achievement of, or failure to achieve, long-term recovery. For example, multi-site studies of addiction treatment have linked the best outcomes to such program characteristics as clear treatment policies, high expectations of clients, highly structured treatment activities, high rates of staff in recovery, and a wider range of psychosocial services.[94] Such positive outcomes have also been linked to broader organizational infrastructure characteristics and to the broader policy environment.[95]

Infrastructure is the institutional platform upon which services are built to promote long-term recovery for individuals and families. Key indicators of infrastructure stability measure the degree to which addiction treatment as a professional field and local addiction treatment organizations can ensure the safety, continuity, and quality of care provided to individuals, families, and communities. Success stories related to work on the infrastructure of addiction treatment over the past 40 years include designated federal and state authorities for AOD problems; a federal, state, local and private financing partnership; widespread licensure and accreditation of addiction treatment programs; preparatory education and training programs for addiction service professionals; and addiction professional licensure and certification programs. Such successes have been critical to building a national network of addiction treatment programs and enhancing service quality and client safety.

In spite of these achievements, a number of infrastructure vulnerabilities raise a troubling question: *if addiction is a chronic illness requiring sustained monitoring, support, and early re-intervention, can the current acute-care model of addiction treatment provide such continuity of support over an extended period of time?*[96] Indicators of infrastructure strength particularly important to recovery management include:

- a recovery-focused organizational culture;
- adequate capitalization, funding diversification, availability of funding streams that enable sustained support, and financial stewardship;
- stability of organizational ownership;
- administrative and clinical leadership and workforce stability;
- recovery representation at policy and clinical decision-making levels;

94. Moos, R.H., King, M.J., Burnett, E.B., & Andrassy, J.M. (1997). Community residential program policies, services and treatment orientations influence patients' participation in treatment. *Journal of Substance Abuse*, *9*, 171-187; Joe, G.W., Simpson, D.D., & Hubbard, R.L. (1991). Treatment predictors of retention in methadone maintenance. *Journal of Substance Abuse*, *3*, 73-84.

95. Ghose, T. (2008). Organizational- and individual-level correlates of posttreatment substance use: A multilevel analysis. *Journal of Substance Abuse Treatment*, *34*, 249-262.

96. 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.

- safety protocols for service providers and consumers;
- technological capabilities; and
- institutional relationships with local communities (with particular emphasis on communities of recovery).

The next chapter will evaluate the current state of addiction treatment based on a sampling of these performance measures.

Adaptive or absorptive capacity refers to the resources the system/organization can mobilize to initiate and sustain processes of self-change. Adaptive capacity is a measure of organizational health and resilience and is influenced by the professionalism of organizational members, the frequency and accuracy of environmental scanning, and the collection and utilization of feedback from multiple organizational stakeholders (e.g., service consumers and service buyers).[97] More specifically, it addresses the degree to which addiction treatment as a system of care can recognize major service design flaws and initiate and sustain system-transformation processes aimed at correcting such flaws.

Adaptive capacity measures the organization's ability to maintain service support while initiating and sustaining change processes. For example, organizations that are hopelessly over-extended may recognize the need to change their service design from an AC to a RM model of care, but may lack the energy and resources to start and complete such a transformation process. There are frameworks for assessing a particular organization's readiness to change,[98] but no comparable instrument exists to assess the readiness of an entire professional field to shift its operating paradigm.

## Recovery-focused Service Process Measures

Recovery-focused service process measures are intermediate measures that exert an influence on long-term recovery outcomes. For purposes of this paper, we will evaluate the current system of addiction treatment using eight recovery-focused process measures: 1) treatment attraction and access; 2) screening, assessment, and level-of-care placement; 3) composition of the service team; 4) service relationship (engagement, retention, and discharge status); 5) service dose, scope, and quality; 6) locus of service delivery and influence on the post-treatment recovery environment; 7) assertive linkage to communities of recovery; and 8) post-treatment monitoring, support, and early re-intervention. Chapters Six through Thirteen will provide brief evaluations of addiction treatment using these key recovery-focused process measures.

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97. While client-reported satisfaction with a treatment experience may affect intermediate outcomes (e.g., level of participation), not all studies have found that such satisfaction is correlated with post-treatment recovery outcomes (Siqueland, L. Crits-Christoph, P., Barber, J., Connolly Gibbons, M.B., Gallop, R., Griffin, M., Frank, A., Thase, M.E., Luborsky, L., & Liese, B. (2004). What aspects of treatment matter to the patient in the treatment of cocaine dependence? *Journal of Substance Abuse Treatment*, *14*, 565-572.); 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.

98. Lehman, W.F.K., Greener, J.M., & Simpson, D.D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, *22*, 197-209.

## Long-term Recovery Outcome Measures

Treatment/recovery outcome measures vary widely, with considerable disagreement about how to define such terms as *relapse and recovery.*[99] There is, for example, evidence that abstinence or achievement of sustained levels of subclinical use may be obtained without concomitant improvements in criminal lifestyle, health, employment, income, and housing.[100] For purposes of this paper, we will posit that the purpose of treatment is recovery and define long-term recovery in terms of 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).[101] These broad arenas embrace four of the seven performance domains that are part of SAMHSA's National Outcome Measures: abstinence from drug use and alcohol abuse, finding and keeping a job or enrolling or staying in school, decreased criminal justice system involvement, safe and stable housing, and social connectedness.[102]

Traditionally, such measures of treatment outcomes have been collected at a single point in time, but the growing understanding of addiction as a chronic disorder suggests the importance of measuring these outcomes at multiple points in time, to accurately evaluate the courses of both addiction and recovery careers.[103] We will use the available treatment outcome research to evaluate the extent to which the acute-care model of addiction treatment in the United States can achieve these three dimensions of recovery. We will also provide a table of promising practices related to each area of performance. These suggestions are drawn from the published literature or represent practices currently being piloted that have yet to be evaluated. Chapters Six through Thirteen will also include examples of measurable, recovery-linked benchmarks that might be utilized to evaluate each area of performance.

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99. Maddux, F.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.

100. 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.

101. 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. (2007b). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*, 229-241; 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.

102. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2002). Year 2000 discharges by reason for discharge, according to type of service: TEDS 2000. (Number and percent distribution). Retrieved February 20, 2008, from http://www.dasis.samhsa.gov/teds00/6.3a.htm

103. 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.

## SUMMARY: RECOVERY-FOCUSED SYSTEM PERFORMANCE MEASURES

**I. Infrastructure Strength and Adaptive Capacity**

A. Recovery representation/orientation
B. Organizational health and stability
C. Health and stability of administrative/clinical leadership
D. Cultural/political status
E. Capitalization, funding diversification
F. Availability of funding streams for sustained support
G. Financial stewardship
H. Institutional relationships
I. Workforce composition and stability
J. Technological capabilities
K. Adaptive capacity

**II. Recovery-focused Service Process Measures**

A. Treatment attraction and access
B. Screening, assessment, and level-of-care placement
C. Composition of the service team
D. Service relationship (engagement, retention, and discharge status)
E. Service dose, scope, and quality
F. Locus of service delivery/Influence on the post-treatment recovery environment
G. Assertive linkage to communities of recovery
H. Post-treatment monitoring, support, and early re-intervention

**III. Recovery Outcome Measures**

A. Pre-post treatment changes in:
   - AOD use/consequences
   - Living environment
   - Physical health and health care costs
   - Emotional health
   - Family relationships and family health
   - Citizenship (legal status, education, employment, community participation, community service)
   - Quality of life (spirituality, life meaning, and purpose)

B. Post-treatment Service/Support Utilization Patterns
   - Utilization of professional services
   - Utilization of indigenous recovery support institutions

C. Changes in Family and Community Recovery Capital

# Chapter Four

## The Infrastructure of Addiction Treatment

### ■ SUMMARY OF KEY POINTS ■

- Measurable elements of addiction treatment infrastructure required to fully implement an RM model include recovery orientation and representation, leadership stability, an esteemed status of addiction treatment as a cultural and community institution, capitalization and funding diversification, availability of funding streams for sustained recovery support, financial stewardship, organizational stability, workforce stability, technological capabilities, and adaptive capacity.
- Recovery advocates perceive a historical weakening of the recovery orientation of addiction treatment programs; in their view, addiction treatment has become detached from the larger and more enduring process of long-term recovery.
- The extension of the AC model of treatment to an RM model will require repositioning addiction treatment as a cultural institution and re-educating the public and policymakers about the nature of addiction and its treatment.
- The shrinking proportion of health care resources devoted to addiction treatment and the growing reliance on governmental funding for treatment will limit resources and demand effective stewardship of the resources that can be mustered to support systems-transformation efforts.
- The move to an RM model will require substantial changes in funding policies and mechanisms to facilitate the development of long-term recovery support services.
- Challenges to systems-transformation efforts include the instability of addiction treatment organizations, the mass exodus of long-tenured leaders within the addiction treatment field, and the lack of system-wide programs of leadership development and succession planning.
- Ensuring continuity of contact in long-term recovery support relationships will require reversal of the currently high annual turnover rate of the addiction treatment workforce.
- Efforts to create ROSC and to shift local treatment agencies toward an RM orientation will require tandem efforts to strengthen the national infrastructure of addiction treatment in the United States and the infrastructures of local addiction treatment service providers. Lacking such efforts, ROSC and RM will constitute only a new rhetoric and isolated pockets of innovation rather than a true transformation of the system of care.

There is increasing expression of concerns about the health and stability of the 13,200 specialty programs that are at the core of today's addiction treatment infrastructure.[104] Key concerns include the following issues.

## Recovery Representation and Orientation

Recovery advocates over the past decade have lamented the absence of long-term recovery orientation in addiction treatment organizations. They allege that treatment has become detached from the larger and more enduring process of recovery.[105] Advocates see no references to recovery in the statements of mission, vision, and core values of addiction treatment programs, and they attribute this to what they see as an erosion of recovery representation at all levels of decision making within the addiction treatment field. They have witnessed a progressive decline in the number of addiction professionals with personal recovery experience and a weakening of institutional linkage between treatment organizations and local communities of recovery and indigenous recovery support institutions.[106]

Recovery representation has only recently begun to increase at the national level, through the work of organizations like Faces and Voices of Recovery and the Johnson Institute. Parallel changes at the local level are reflected in the increased use of recovering people as paid staff and volunteers working as outreach workers and recovery coaches. The development of recovery-oriented systems of care and recovery management approaches to addiction treatment can reflect deep changes in treatment philosophy and practices or a superficial adaptation to the latest "flavor of the month" chase for funds. The former will come only through a focused recovery re-orientation process within each organization. That re-orientation is already underway in many organizations.

## Organizational Health and Stability

The role of a treatment center within a recovery-oriented system of care is one of maintaining continuity of support for the clients and communities it serves over time. The current high rates of closure (15% over two years) and re-organization (29% over two years) of addiction treatment programs undermine such capacities for continuity of support.[107] The number of specialized addiction treatment programs has dropped from more than 16,000 in 1990 to 13,200 specialty programs today.[108]

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104. McLellan, A.T., Carise, D., & Kleber, H.D. (2003). The national addiction treatment infrastructure: Can it support the publicís demand for quality of care? *Journal of Substance Abuse Treatment*, *78*, 125-129; McLellan, A.T., & Meyers, K. (2004). Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry*, *56*(10), 764-770; Substance Abuse and Mental Health Services Administration. (2006). Strengthening Professional Identity: Challenges for the Addiction Treatment Workforce. Center for Substance Abuse Treatment. Retrieved on July 30, 2008, from http://www.samhsa.gov/matrix2/matrix_workforce.aspx; Roman, P.M., Ducharme, L.J., & Knudsen, H.K. (2006). Patterns of organization and management in private and public substance abuse treatment programs. *Journal of Substance Abuse Treatment*, *31*, 235-243; Evans, W.N., & Hohenshil, T.H. (1997). Job satisfaction of substance abuse counselors. *Alcoholism Treatment Quarterly*, *15*, 1-13.

105. White, W. (2004b). Recovery: The next frontier. *Counselor*, *5*(1), 18-21.

106. Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

107. McLellan, A.T., Carise, D., & Kleber, H.D. (2003). The national addiction treatment infrastructure: Can it support the publicís demand for quality of care? *Journal of Substance Abuse Treatment*, *78*, 125-129.

108. McLellan, A.T., & Meyers, K. (2004). Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry*, *56*(10), 764-770.

Organizations working with stigmatized issues and stigmatized service consumers are prone to processes of "incestuous closure" that undermine service quality and the health and viability of organizations and their service providers.[109] Pioneering addiction treatment organizations (e.g., Synanon) have imploded in the aftermath of such processes, leaving in their wake legacies of abuses that have added to the professional literature on therapeutic cults.[110] Grassroots helping organizations are also prone to become "chaotically disengaged systems"—a process through which their historical mission and core values are lost in the transition from a community-based service organization to a behavioral health care business. Organizational boundary closure at one extreme—and complete organizational boundary permeability without gatekeeping at the other extreme—distort organizational values and create role stressors (e.g., role conflict, role ambiguity, role overload, etc.) that undermine clinical performance and clinical outcomes.[111]

There is a direct connection between organizational structure, health, and functioning and client outcomes as measured by client engagement, satisfaction, and service outcomes.[112] Programs that lack structure, high client expectations, and energetic and goal-directed staff suffer from high drop-out rates, low linkage to recovery support groups, and poor post-treatment recovery outcomes.[113] The consistency, clarity, and strength of the program philosophy and service structure and the presence of high expectations for participation are more predictive of client outcomes than either client characteristics or the theoretical orientation of the program.[114] Recovery management requires a stable foundation upon which long-term recovery support relationships can be built. Organizational instability and impaired organization health in the field will slow the speed of overall system-transformation efforts and the ability of organizations to implement particular technological changes in their service protocols.

## Leadership Stability

There is no delicate way to put this: As a field, we are getting old. The exodus of long-tenured administrative and clinical leaders has already begun and will rapidly escalate over the next 5-7 years. While alarms resound about this impending crisis in leadership,[115] there is no system-wide strategy of leadership development and succession planning for the field. Leadership transitions constitute a drain on the field's energies and raise the question of whether or not a new generation of leaders can be mobilized to lead a recovery-focused redesign of addiction treatment that will take years, if not decades. That question has yet to be answered.

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109. White, W. (1997c). *The incestuous workplace: Stress and distress in the organizational family* (2nd ed.). Center City, MN: Hazelden.

110. Jansen, R. (2001). *The rise and fall of Synanon*. Baltimore, MD: The Johns Hopkins University Press.

111. White, W. (1997c). *The incestuous workplace: Stress and distress in the organizational family* (2nd ed.). Center City, MN: Hazelden.

112. Greener, J.M., Joe, G.W., Simpson, D., Rowan-Szal, G.A., & Lehman, W.E.K. (2007). Influence of organizational functioning on client engagement in treatment. *Journal of Substance Abuse Treatment*, *33*, 139-147.

113. Moos, R.H., & Moos, B.S. (1998). The staff workplace and the quality and outcomes of substance abuse treatment. *Journal of Studies on Alcohol*, *59*, 43-51.

114. Moos, R.H., King, M.J., Burnett, E.B., & Andrassy, J.M. (1997). Community residential program policies, services and treatment orientations influence patients' participation in treatment. *Journal of Substance Abuse*, *9*, 171-187.

115. White, W.L. (2002b). Leadership in addiction treatment: The coming crisis. *Counselor*, *3* (3), 60-61; White, W., & Hagen, R. (2006). Leadership development, succession planning and graceful disengagement (10 Steps to leaving an organization in good hands). *Behavioral Healthcare*, *26*(1), 32-34.

## Cultural/Political Status

Issues rise and fall and rise again in cultural prominence, and these cycles shape the fate of social institutions and the lives they impact. Does the addiction field have the political capital to generate the resources needed to support systems-transformation efforts? The decline in the number of our single state agencies that constitute independent departments with direct gubernatorial and legislative access would suggest that we are in a marginal position at best. We are not well positioned to face an economic crisis in which policymakers will be forced to decide between roads, schools, day care, and addiction treatment. There is also a question of whether addiction treatment as a field has the political capital to transform itself in the face of resistance from institutions whose future professional and financial interests are best served by the current acute-care model of addiction treatment. That resistance is and will be substantial.

## Capitalization, Funding Level, and Diversification

Concerns of note here include the erosion of resource allocation for AOD problems in proportion to other health arenas, the decline in insurance revenues supporting addiction treatment (and the commensurate decrease in services provided), and the addiction treatment field's growing reliance on governmental funding (80% of current revenues).[116] How can the field bear the costs of system-transformation activities and maintain service responsiveness through the change process—all in an environment of tightening resources? The reliance on government funding and the unknown degree of capitalization of addiction treatment programs constitute major sources of vulnerability and raise the question of how the field's infrastructure could be sustained through a period of sustained economic austerity.

A related question concerns the extent to which existing financial resources can be strategically allocated to support proximal (short-term) or distal (long-term) recovery outcome measures. One promising practice is the Delaware Division of Substance Abuse and Mental Health's movement to an incentivised system of performance-based contracting—a move that resulted in increased service utilization and client participation in treatment.[117]

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116. Mark, T.L., Coffey, R.M., McKusick, D.R., Harwood, H., King, E., Bouchery, E., Genuardi, J., Vandivort, R., Buck, J., & Dilonardo, J. (2005). *National estimates of expenditures for mental health services and substance abuse treatment*, 1991-2001 (SAMHSA Publication No. SMA 05-3999). Rockville, MD: Substance Abuse and Mental Health Services Administration; Mark, T.L., & Coffey, R.M. (2004). Trends: The decline in receipt of substance abuse treatment by the privately insured, 1992-2001. *Health Affairs*, *23*(6), 157-162.

117. McLellan, A.T., Kemp, J., Brooks, A. and Carise, D. (in press). Improving public addiction treatment through performance contracting: The Delaware experiment. *Health Policy*.

## Availability of Funding Streams for Sustained Support

The existing funding streams that support addiction treatment evolved in tandem with the AC model of treatment. It is unlikely that the extension of the AC model to a more encompassing model of sustained recovery management will be possible without a restructuring of funding policies and mechanisms. That restructuring process is already underway in states that are embarking on recovery-focused systems-transformation processes, e.g., Connecticut, Arizona, Florida, and Michigan. Examples of such changes include revision of Medicaid rules to allow for reimbursement of peer-based post-treatment recovery support services, rate renegotiations to include recovery support services, and incentive payments for embracing elements of the RM model.

At this late stage in the field's development, we simply have no scientific consensus on what mechanisms of funding best support long-term recovery outcomes. Modern funding in the public sector has shifted from a grant-based program funding model to the fee-for-service model through which private health care had long operated. This shift contributed to a narrowing of services offered, now limited to those services approved for reimbursement and billing in the fee-for-service system, leaving that system poorly designed to support the broad range of service supports needed by many clients to sustain long-term recovery. As momentum builds to shift addiction treatment from a focus on acute biopsychosocial stabilization to long-term recovery management, there will be growing pressure to rethink how such services are best funded. Current discussions of alternatives include "capitated rate," "case-rate," payment for performance, and incentive models that use proximal and distal recovery outcomes as a basis for baseline or enhanced reimbursement.[118]

## Financial Stewardship

The shift to a focused recovery orientation creates the ultimate criterion for organizational decisions related to the allocation of available resources: Will spending these dollars on this project enhance the recovery outcomes for the individuals, families, and communities we serve? As recovery representation increases at policy levels within the field, greater accountability will ensue related to financial stewardship. The resulting controversies related to everything from executive compensation to contracting practices have the potential to injure particular organizations and the field as a whole.

118. Michael Flaherty, personal communication, June 6, 2008; Ken Ramsey, personal communication, May 19, 2008.

## Workforce Stability and Composition

Specialized addiction treatment in the United States is delivered by more than 130,000 full-time and more than 45,000 part-time staff.[119] That workforce is marked by low morale (via high caseloads, excessive paperwork, and low pay), high future intent to change jobs (76%), and high rates of annual staff turnover (ranging from as low as 13% to as high as 50-60%). Many treatment organizations are plagued by a "culture of turnover" and limitations on service capacity imposed by unfilled service positions and difficulties in recruiting qualified persons.[120]

Workforce characteristics, including the feminization of a field serving a predominately male clientele and the fact that a predominately White staff is serving a growing population of non-White clients (now 43% of incoming clients), are also of concern. The workforce is also aging, with the average age of clinical staff ranging from 45-55, while the average age of clients entering treatment is declining.[121] If current trends continue, a predominately White, middle-aged female staff will be counseling a predominately young, non-White male clientele.

A December, 2007 NAADAC survey of 6,241 of its 9,500 members revealed that 79% of respondents were over 50 and less than 6% were under 40.[122] While these survey data may not reflect total NAADAC membership or all addiction counselors in the country, they confirm the trend toward an aging workforce documented in multiple regional and state workforce surveys (e.g., workforce surveys of the Addiction Technology Transfer Centers).

Other workforce concerns include the following:

- As many as 25% of direct service staff do not possess any professional credentials and are not in the process of obtaining such credentials.[123]
- Studies note wide variations in treatment completion and post-treatment recovery outcomes across counselors,[124] but studies of staff turnover do not reveal whether the addiction treatment field is losing its most or least effective counselors.
- Most addiction treatment programs use medical metaphors to conceptualize the addiction, treatment, and recovery processes, but most people undergoing addiction treatment in the United States have little contact with physicians, nurses, or other medical personnel during their treatment, and only slightly more than half undergo a physical exam as part of their treatment.[125]
- Those with the greatest clinical experience in the treatment field serve in administrative and supervisory positions that afford little if any contact with individuals and families seeking services.[126]

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119. Kaplan, L. (2003). Substance abuse treatment workforce environmental scan. Rockville, MD: Center for Substance Abuse Treatment.

120. Evans, W.N., & Hohenshil, T.H. (1997). Job satisfaction of substance abuse counselors. *Alcoholism Treatment Quarterly*, *15*, 1-13; Roman, P.M., Ducharme, L.J., & Knudsen, H.K. (2006). Patterns of organization and management in private and public substance abuse treatment programs. *Journal of Substance Abuse Treatment*, *31*, 235-243; DíAunno, T. (2006). The role of organization and management in substance abuse treatment: Review and roadmap. *Journal of Substance Abuse Treatment*, *31*, 221-233; Kaplan, L. (2003). Substance abuse treatment workforce environmental scan. Rockville, MD: Center for Substance Abuse Treatment.

121. Kaplan, L. (2003). Substance abuse treatment workforce environmental scan. Rockville, MD: Center for Substance Abuse Treatment; Kimerly, J.R., & McLellan, A.T. (2006). The business of addiction treatment: A research agenda. *Journal of Substance Abuse Treatment*, *31*, 213-219; McLellan, A.T., & Meyers, K. (2004). Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry*, *56*(10), 764-770; Evans, W.N., & Hohenshil, T.H. (1997). Job satisfaction of substance abuse counselors. *Alcoholism Treatment Quarterly*, *15*, 1-13.

122. NAADAC. (2007). NAADAC Demographics, December 31, 2007. Personal communication, February 20, 2008.

123. Kaplan, L. (2003). Substance abuse treatment workforce environmental scan. Rockville, MD: Center for Substance Abuse Treatment.

124. McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an ìactive ingredientî in substance abuse rehabilitation? An examination of treatment success among four counselors. *Journal of Nervous and Mental Disorders*, *176*(7), 423-430; Blaney, T., & Craig, R.J. (1999). Methadone maintenance: Does dose determine differences in outcome? *Journal of Substance Abuse Treatment*, *16*(3), 221-228.

125. McLellan, A.T., Grissom, G.R., Brill, P., Durell, J., Metsger, 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.

126. Kaplan, L. (2003). Substance abuse treatment workforce environmental scan. Rockville, MD: Center for Substance Abuse Treatment.

Studies have not been conducted that measure the effects of service team composition and characteristics on long-term recovery outcomes. For example, substantial investments have been made in the development of special credentials (e.g., certification or licensure) for physicians, psychologists, and counselors specializing in addiction treatment, but no existing studies document the assertion that clients achieve better recovery rates if they have been treated by certified rather than non-certified service staff. The professionalization of the addiction treatment workforce rested on the assumption that such professionalization would enhance treatment outcomes, but this assumption has yet to be empirically tested.[127]

## Technological Capabilities

Surveys of addiction treatment programs reveal weak technological capabilities in the field, with only a minority of programs having integrated clinical information systems available for use by clinical staff. Some programs (20%) lack even voicemail or email capabilities.[128] Managing the course of a disorder over time requires far greater technological sophistication in terms of information management than managing a self-encapsulated episode of brief care. The move to an RM model of care will require substantial efforts to upgrade the technological capabilities of the field.

## Adaptive Capacity: Infrastructure Weakness as an Obstacle to Systems Transformation

The above-noted infrastructure concerns raise the question of whether addiction treatment organizations and the field as a whole possess the capabilities to undertake, sustain, and successfully complete a fundamental redesign of addiction treatment. That concern extends to both private and public addiction treatment programs, with each sector bringing its own resources and constraints. For example, private programs are more likely to be larger, accredited, staffed with master's-educated counselors, and to employ pharmacotherapies; but public programs are more likely to provide ancillary services and methods that are critical to long-term recovery management, e.g., transportation and day care, mental health counseling, and voucher-based motivational incentives.[129]

The infrastructure problems of the addiction treatment field are being recognized, and efforts are underway in several key areas, particularly in leadership and workforce development initiatives.[130] Efforts are also underway to identify particular management practices linked to enhanced retention of direct service staff (e.g., increased job autonomy, rewards for job performance).[131]

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127. McLellan, A.T. (2006). What we need is a system: Creating a responsive and effective substance abuse treatment system. In Miller, W.R. & Carroll, K.M. *Rethinking substance abuse: What the science shows, and what we should do.* NY: Guilford Press, pp. 275-292.

128. 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.

129. Roman, P.M., Ducharme, L.J., & Knudsen, H.K. (2006). Patterns of organization and management in private and public substance abuse treatment programs. *Journal of Substance Abuse Treatment*, *31*, 235-243; Ghose, T. (2008). Organizational- and individual-level correlates of posttreatment substance use: A multilevel analysis. *Journal of Substance Abuse Treatment*, *34*, 249-262.

130. Carroll. K.M., Ball, S.A., Nich, C., Martino, S., Frankforter, T.L., Farentinos, C., Kunkel, L.E., Mikulich-Gilbertson, S.K., Morgenstern, J., Obert, J.L., Polcin, D., Snead, N., & Woody, G.E., for the National Institute on Drug Abuse Clinical Trials Network. (2006). Motivational Interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence*, *81*, 301-312; McLellan, A.T., Carise, D., & Kleber, H.D. (2003). The national addiction treatment infrastructure: Can it support the publicís demand for quality of care? *Journal of Substance Abuse Treatment*, *78*, 125-129.

131. Knudsen, H.K., Johnson, J.A., & Roman, P.M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment*, *24*, 129-135.

## TABLE 1: RECOVERY-LINKED INFRASTRUCTURE PERFORMANCE MEASURES

| PERFORMANCE ARENA | SAMPLE OF RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Recovery Orientation | Recovery-focused mission statement<br>Articulation of core recovery values<br>Philosophy of choice that acknowledges multiple recovery pathways |
| Recovery Representation | Recovery representation on Governing Board<br>Recovery advisory group<br>Inclusion of Consumer Council and Alumni Association in organizational decision-making<br>Recovery representation among staff and volunteers |
| Cultural/Political Status | Departmental level of state organization (direct access to the Governor/Legislature)<br>Per-capita funding in relationship to other health and behavioral problems<br>Surveys of public perception of addiction, addiction treatment, and recovery |
| Organizational & Leadership Stability | Turnover rate at executive and senior clinical levels<br>Up-to-date succession plans for key leaders<br>Stability of organizational ownership<br>Ownership of service facilities<br>Cash reserves |
| Funding Level & Diversity | Five-year funding trajectory<br>Number of funding sources<br>Percentage of budget coming from a single funding source<br>Availability of funding for pre-treatment, in-treatment, and post-treatment recovery support services |
| Workforce Composition & Stability | Annual turnover rate of direct service staff<br>Comparison of client and staff demographics |

# Chapter Five

## Who Receives Addiction Treatment?

## The Variability of AOD Problems and Their Patterns of Resolution

### ■ SUMMARY OF KEY POINTS ■

- There are marked differences between AOD problems seen in the larger community and those seen in specialty-sector addiction treatment settings.
- Those with AOD problems seen in clinical settings are marked by greater personal vulnerability; greater problem severity, complexity, and chronicity; and lower levels of recovery capital.
- Strategies of natural recovery, moderated resolution of AOD problems, and resolution of AOD problems through brief intervention that are quite viable in community populations have less utility with the clinical population now entering addiction treatment in the United States.
- The effective treatment of AOD problems requires a clear formalization and delineation of strategies distinguishing transient and less severe AOD problems from AOD problems of great severity, complexity, and chronicity.
- The most fundamental issue facing the field of addiction treatment is whether the field claims ownership of all AOD-related problems (and changes its treatment philosophies and service practices to fulfill that claim) or claims only a portion of AOD-related problems (e.g., only substance use disorders or only substance dependence), leaving less severe AOD problems to other social institutions.

Before examining key recovery-focused process measures for addiction treatment, we will outline the variability of AOD problems and the ways in which their resolution strategies differ along five critical factors:

- personal vulnerability (e.g., family history of AOD problems, age of onset of regular AOD use, traumatic victimization),
- problem severity (subclinical AOD problems, *substance abuse, substance dependence,* and variability of levels of severity within these categories),

- problem complexity (polydrug use, presence of co-occurring medical psychiatric disorders, obstacles to recovery),
- problem course (short, moderate, or prolonged AOD-use careers), and
- recovery capital (the total intrapersonal, interpersonal, and community resources that can be brought to bear on the initiation and maintenance of recovery).[132]

The data presented will document the following finding: a large percentage of persons in the community who meet criteria for substance abuse and dependence achieve remission with low relapse rates, but this pattern of resiliency is obscured by the 10-25% of persons with AOD problems who experience chronic and severe courses of such problems.[133]

## The Life Course of AOD Problems in the United States

Patterns of alcohol and drug use vary markedly across the life cycle. Such patterns exist on a continuum demarcated by non-use, minimal use, regular use, episodic heavy use, risky use (dosages, combinations, and contexts that threaten self or others), and regular heavy use.[134] Severe alcohol and other drug problems have been diagnostically classified in terms of *substance abuse and substance dependence* based on factors of severity and duration.[135] Substance abuse is on the increase in the United States, while the prevalence of substance dependence is decreasing.[136] There also is a much wider span of problematic AOD use not captured within these diagnostic classifications.[137]

Not all alcohol and other drug problems constitute chronic disorders.[138] Alcohol and drug problems are often portrayed as having an inevitably "progressive" nature, but evidence from community population studies suggests the opposite. There is, for example, no inevitable progression from *alcohol abuse to alcohol dependence.*[139] Sustained alcohol or drug use without acceleration is common, as is the movement toward deceleration of alcohol and drug problems with age-related maturation.[140] This latter pattern is historically underestimated[141] and constitutes the most common pathway of AOD problem resolution.[142]

Figure 1 illustrates how AOD problems rise through adolescence, peak in early adulthood, decelerate in mid-adulthood, and migrate toward abstinence and reduced regular use in late adulthood. We will explore the differences between those who fit this norm and those for whom AOD problems persist in duration and severity.

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132. Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment.* New York: New York University Press; White, W. & Cloud, W. (in press). Recovery capital: A primer for addiction professionals. *Counselor.*

133. De Bruijn, C., van den Brink, W., de Graaf, R., & Vollenbergh, W.A.M. (2006). The three-year course of alcohol use disorders in the general population: DSM-IV, ICD-10 and the Craving Withdrawal Model. *Addiction*, *101*(3), 385-392.

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135. American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

136. Grant, B.F., Dawson, D.A., Stinson, F.S., Chou, S.P., Dufour, M.C. & Pickering, R.P. (2004). The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence, United States, 1991-1992 and 2001-2002. *Drug and Alcohol Dependence*, *74*(3), 223-234.

137. Saha, T.D., Chou, S.P. & Grant, B.F. (2006). Toward an alcohol use disorder continuum using item response theory: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Psychological Medicine*, *36*, 931-941.

138. McLellan, A.T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, *97*, 249-252.

139. 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; Harford, T.C., Yi, H., & Hilton, M.E. (2006). Alcohol abuse and dependence in college and noncollege samples: A ten-year prospective follow-up in a national survey. *Journal of Studies on Alcohol*, *November*, 803-809.

140. Grant, B.F., Dawson, D.A., Stinson, F.S., Chou, S.P., Dufour, M.C. & Pickering, R.P. (2004). The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence, United States, 1991-1992 and 2001-2002. Drug *and Alcohol Dependence*, *74*(3), 223-234; Fillmore, K.M. (1974). Drinking and problem drinking in early adulthood and middle age. *Quarterly Journal of Studies on Alcohol*, *35*, 819-840; Karlamangla, A., Zhou, K., Reuben, D. Greendale, G., & Moore, A. (2006). Longitudinal trajectories of heavy drinking in adults in the United States of America. *Addiction*, *101*, 91-99; Murphy, S.B., Reinarman, C., & Waldorf, D. (1989). An 11-year follow-up of a network of cocaine users. *British Journal of Addiction*, *84*, 427-436.

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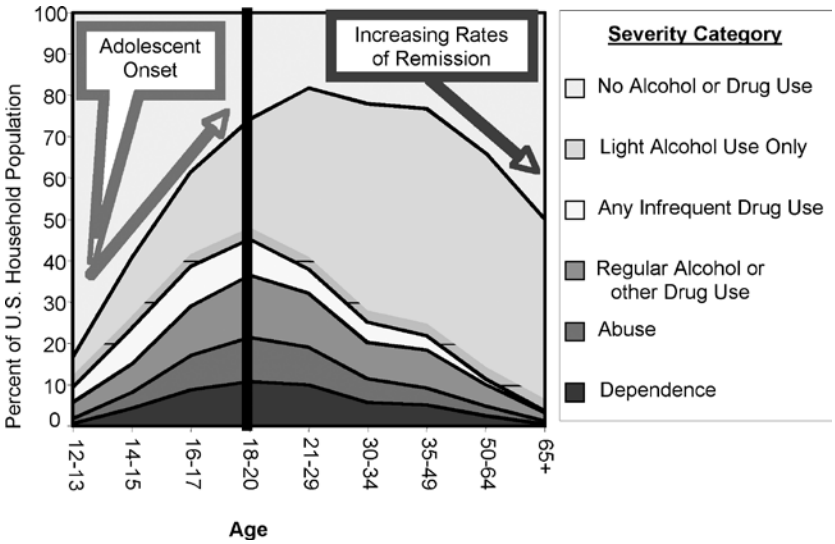
142. Fillmore, K.M., Hartka, E., Johnstone, B.M., Speiglman, R., & Temple, M.T. (1988). *Spontaneous remission of alcohol problems: A critical review.* Washington, D.C.: Institute of Medicine; Sobell, L.C., Sobell, M.C., Toneatto, T., & Leo, G.I. (1993). What triggers the resolution of alcohol problems without treatment? *Alcoholism: Clinical and Experimental Research*, *17*(2), 217-224; Cunningham, J. (1999). Untreated remission from drug use: The predominant pathway. *Addic-*

**FIGURE 1:**

**DISTRIBUTION OF AOD USE/PROBLEMS BY AGE IN GENERAL U.S. POPULATION**

Source: Dennis & Scott, 2007 & OAS, 2002, reprinted with permission[143]




## Natural Recovery

Many persons experiencing AOD problems resolve these problems on their own, particularly when the problems are of later onset and lower severity.[144] The resolution of alcohol and other drug problems without professional assistance or formal recovery support group involvement has been christened with many terms in the research literature: *maturing out,*[145] *autoremission*,[146] *self-initiated change,*[147] *unassisted change*,[148] *spontaneous remission*,[149] *de-addiction,*[150] *self-change,*[151] *natural recovery*,[152] *self-managed change*[153] and *quantum change.*[154]

Natural recovery may contain multiple populations: those who achieve sustained abstinence, those who achieve sustained moderated AOD use, those who continue to have subclinical AOD problems

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that no longer meet criteria for substance abuse or substance dependence, and those who move in and out of these patterns.[155]

A study of Vietnam veterans revealed that only 1% of soldiers addicted to heroin in Vietnam continued this addiction upon their return to the United States. Most stopped using heroin without any formal treatment.[156] A long-term (11-year) follow-up study of a network of cocaine users found diverse cocaine-use career outcomes: 1) continuous controlled use, 2) controlled use to heavy use to controlled use, 3) controlled use to heavy use to abstinence, 4) controlled use to abstinence, and 5) continued heavy use.[157] In the trajectory of cannabis use from high school into adulthood, less than 25% of moderate-risk adolescent users progress to high-risk use in adulthood. Weekly or more frequent cannabis use in adolescence multiplies the odds of daily cannabis use in adulthood sevenfold and doubles the risk of high-risk drinking in adulthood.[158]

In studies of the factors that contributed to natural recovery from AOD problems, natural recovery from AOD problems might constitute:

- the outcome of a deliberate self-evaluation of developing problems and/or life aspirations;[159]
- a pattern of maturing out of AOD use in the transition from adolescence to young adulthood or to middle adulthood, particularly in persons with considerable physical and psychological resiliency and family and social support;[160]
- a shift in behavior triggered by a transitional life event (e.g., completing school, starting a career, entry into or exit from marriage, becoming a parent) that alters personal identity and lifestyle and generates increased recovery capital;[161]
- a culturally prescribed pathway of recovery unique to particular ethnic communities;[162] or
- a behavioral shift accompanying environmental change, e.g., remission of addiction in the transition from a combat environment to a civilian environment, as occurred with most heroin-addicted soldiers returning from Vietnam.[163]

Many individuals who experience AOD problems in community populations also resolve these problems through brief intervention outside the arena of specialized addiction treatment. These brief interventions may be conducted by other health and human service professionals or by trained non-professionals in recovery.[164] Brief interventions have been designed and evaluated primarily with non-dependent populations,[165] but recent studies suggest that these interventions may also have utility with dependent drinkers.[166]

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147. Biernacki, P. (1986). *Pathways from heroin addiction: Recovery without treatment*. Philadelphia: Temple University Press.

148. McMurran, M. (1994). *The Psychology of Addiction*. Washington, D.C.: Taylor and Francis.

149. Anthony, J.C., & Helzer, J.E. (1991). Syndromes of drug abuse and dependence. In L.N. Robins & D.A. Regier (Eds)., *Psychiatric disorders in America: The Epidemiologic Catchment Area Study*. New York: The Free Press.

150. Frykholm, B. (1985). The drug career. *Journal of Drug Issues, 15,* 333-346; Klingemann, H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of Addiction, 86*, 727-744.

151. Sobell, L.C., Sobell, M.B., & Toneatto, T. (1991). Recovery from alcohol problems without treatment. In N. Heather, W.R. Miller, & J. Greeley (Eds.)., *Self control and the addictive behaviors*. Botany, Australia: Maxwell Macmillan Publishing.

152. Havassy, B.E., Hall, S.M., & Wasserman, D.A. (1991). Social support and relapse: Commonalities among alcoholics, opiate users, and cigarette smokers. *Addictive Behaviors, 16,* 235-246.

153. Copeland, J. (1988). A qualitative study of self-managed change in substance dependence among women. *Contemporary Drug Problems, 25,* 321-345.

154. Miller, W., & C'de Baca, J. (2001). Quantum change: When epiphanies and sudden insights transform ordinary lives. New York: Guilford Press.

155. 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.

156. 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.

157. Murphy, S.B., Reinarman, C., & Waldorf, D. (1989). An 11-year follow-up of a network of cocaine users. *British Journal of Addiction*, *84*, 427-436.

158. 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.

159. 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 age study. *Journal of Studies on Alcohol, 49*(4), 363-368.

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161. 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; Karlamangla, A., Zhou, K., Reuben, D. Greendale, G., & Moore, A. (2006). Longitudinal trajectories of heavy drinking in adults in the United States of America. *Addiction*, *101*, 91-99.

In spite of substantial scientific documentation of their existence, public surveys suggesting the possibility of natural recovery or moderated resolution of alcohol or drug problems (other than nicotine addiction) are often greeted with skepticism.[167] Reports of moderated resolution of AOD problems have also triggered heated professional controversy.[168]

## Community versus Clinical Populations

The documentation of both transient and chronic patterns of AOD use and related problems sparked interest in AOD-use career trajectories. Epidemiologic studies attempted to distinguish non-problem drinkers, transient early problem drinkers, early problem drinkers who progressed to late-life drinking problems, and persons who experienced late-life onset of alcohol problems.[169] The dominant conclusion drawn from these studies is that those seeking specialized addiction treatment differ markedly from the larger pool of individuals experiencing and naturally resolving AOD problems within the community.[170] These differences constitute what have been referred to as the "two worlds" of alcohol and other drug problems.[171]

The knowledge that addiction professionals acquire working with clinical populations does not, as was long thought, provide a knowledge base with which to talk about the larger arena of AOD problems in their communities. This mistaken view that AOD problems in the community are the same as those seen in treatment settings reflects what has been called "Berkson's Fallacy" or the "Clinician's Illusion."[172] The science is unequivocal on this point: 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.[173] Studies of AOD problems in the general population reveal distinct subtypes of persons with AOD problems, only a small, non-representative sample of whom are seen in specialty sector addiction treatment.[174]

Compared to persons experiencing and resolving AOD problems in community samples, adults and adolescents entering specialized addiction treatment are distinguished by:

- greater personal vulnerability (e.g., family history of substance use disorders, child maltreatment, early pubertal maturation, early age of onset of AOD use, personality disorders during early adolescence, substance-using peers, and greater cumulative lifetime adversities);

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162. Hill, T.W. (1974). From hell-raiser to family man. In J.L. Spradely & G.W. McCurdy (Eds.)., *Conformity & conflict: Reading in cultural anthropology* (2nd edition). Boston: Little Brown & Company; Jilek, W.G. (1978). Native renaissance: The survival of indigenous therapeutic ceremonials among North American Indians. *Transcultural Psychiatric Research, 15*, 117-147; Kunitz, S.J., & Levy, J.E. (1994). *Drinking careers: A twenty-five year study of three Navaho populations*. New Haven, CT: Yale University Press; Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recoveryóThe truth about the lie*. Colorado Springs, CO: White Bison, Inc.; Torres Stone, R.A., Whitebeck, L.B., Chen X., Johnson, K., & Olson, D.M. (2006). Traditional practices, traditional spirituality, and alcohol cessation among American Indians. *Journal of Studies on Alcohol*, *67*, 236-244; Mudar, P., Kearns, J.N., & Leonard, K.E. (2002). Transition to marriage and changes in alcohol involvement among Black couples and White couples. *Journal of Studies on Alcohol*, *63*(5), 568-576.

163. Robins, L.N. (1993). Vietnam veterans; rapid recovery from heroin addiction: A fluke of normal expectation? *Addiction*, *88*, 1041-1054.

164. Wutzke, S.E., Conigrave, K.M., Saunders, J.B., & Hall, W.D. (2002). Long-term effectiveness of brief interventions for unsafe alcohol consumption: A 10-year follow-up. *Addiction*, *97*(6), 665-675; Edwards, G., Orford, J., Egert, S., Guthrie, S., Hawker, A., Hensman, C., Mitcheson, M., Oppenheimer, E., & Taylor, C. (1977). Alcoholism: A controlled trial of "treatment" and "advice." *Journal of Studies on Alcohol*, *38*(5), 1004-1031; Fleming, M.F., Barry, K.L., Manwell, L.B., Johnson, K., & London, R. (1997). Brief physician advice for problem drinkers. *Journal of the American Medical Association*, *277*, 1039-1045; Fleming, M.F., Mundt, M.P., French, M.T., Manwell, L.B., Stauffacher, E.A., & Barry, K.L. (2002). Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical and Experimental Research*, *26*, 36-43; Bien, T., Miller, W., & Tonigan, J. (1993). Brief intervention for alcohol problems: A review. *Addiction*, *88*(3), 315-336; Bernstein, J., Bernstein, E., Tassiopoulos, K., Hereen, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*, 49-59; De Bruijn, C., van den Brink, W., de Graaf, R., & Vollebergh, W.A.M. (2006). The three year course of alcohol use disorders in the general population: DSM-IV, ICD-10 and the Craving Withdrawal Model. *Addiction*, *101*(3), 385-392.

165. Freyer-Adam, J., Coder, B., Baumeister, S.E., Bischof, G., Riedel, J., Paatsch, K., Wedler, B., Rumpf, H.J., John, U., & Hapke, U. (2008). Brief alcohol intervention for general hospital inpatients: A randomized controlled trial. *Drug and Alcohol Dependence*, *93*, 233-243.

166. Guth, S., Lindberg, S.A., Badger, G.J., Thomas, C.S. Rose, G.L. & Helzer, J.E. (2008). Brief intervention in alcohol-dependent versus nondependent individuals. *Journal of Studies on Alcohol and Drugs*, *69*, 243-250.

167. Cunningham, J.A., Sobell, L.C., & Chow, V.M.C. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol*, *54*, 693-699.

168. Sobell, M.B., & Sobell, L.C. (1995). Controlled drinking after 25 years: How important was the great debate? *Addiction*, *90*, 1149-1153.

169. Fillmore, K.M. (1974). Drinking and problem drinking in early adulthood and middle age. *Quarterly Journal of Studies on Alcohol*, *35*, 819-840; 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.

- greater severity (longer duration of use, dependence, polysubstance use, opiate dependence) and intensity (frequency, quantity, high-risk methods of ingestion, and high-risk contexts) of use and greater AOD-related related consequences;
- greater AOD-related legal problems;
- higher rates of developmental trauma and posttraumatic stress disorder;
- higher co-occurrence of other medical/psychiatric illness;
- greater personal and environmental obstacles to recovery; and
- lower levels of recovery capital.[175]

Those individuals needing professionally directed addiction treatment suffer from more than a singular, encapsulated problem with alcohol or other drugs. Need for addiction treatment—particularly prolonged or repeated treatment—is often a proxy for cultural marginalization and the need for sustained guidance into full cultural participation.[176]

Even within those diagnosed with substance use disorders, there is a broad range of variability. There is considerable variation across substance abuse and substance dependence categories (suggesting potentially different etiological pathways) as well as marked variability of severity and complexity within each of these diagnostic categories.[177] Substance dependence often has a prolonged, chronic course, but this is often not the case with substance abuse. Most individuals who meet substance abuse criteria do not progress to substance dependence and often no longer meet *abuse* criteria at a year or more follow-up.[178] Even the minority of studies that have noted such a progression do not find such progression across all drug choices.[179]

Natural recovery is the predominant pathway of resolution for transient substance-related problems and less severe substance use disorders, whereas professionally directed treatment is the dominant pathway of entry into recovery from substance dependence.[180]

This variability of alcohol and other drug problems and their pathways of resolution have been increasingly recognized in the professional literature. In a recent text on addiction science and public policy, William Miller and Kathleen Carroll note:

> *The diagnostic criteria for classifying people with "drug abuse" and "drug dependence" represent arbitrary cut points along a gradual continuum. This means that, as with other conditions,*

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170. 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.

171. 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.

172. Willenbring, M.L. (2008). Heavy drinking & alcohol dependence: Remission & recovery. Presented at the Recovery Symposium, Institute for Research, Education and Training in Addictions, May 2, 2008.

173. Fein, G., & Landman, B. (2005). Treated and treatment-naïve alcoholics come from different populations. *Alcohol*, *35*(1), 19-26.

174. 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.

175. 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., & Johsnon, 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*, *March*, 256-265; 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 Ahmadabad 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*(S), 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 no treatment for alcohol use disorders? Evidence from the National Household Survey on Drug Abuse. *Journal of Studies on Alcohol*, *May*, 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

*society needs to address a wide array of problem severity, and that interventions appropriate to one region of the continuum may be unhelpful or even counterproductive at another level of development.*[181]

## Moderated Resolution of AOD Problems: Community versus Clinical Populations

Studies of the resolution of alcohol problems among community populations reveal a substantial portion of individuals who resolve these problems through decelerated patterns of alcohol use.[182] In a recent study, the remission subgroups within the total sample consisted of 18.2% abstainers, 17.7% low risk drinkers, and 11.8% asymptomatic drinkers.[183] At one-year follow-up in Project MATCH, 7-12% of clients had achieved moderate drinking outcomes.[184] However, there is evidence from long-term follow-up studies that moderated recoveries may be less stable over time than abstinence-based recoveries. In a 16-year follow-up study of treatment—naïve individuals seeking information for decreasing their alcohol use, researchers concluded:

Thus, only a relatively small proportion of individuals initially achieved non-problem drinking following a period of problem alcohol use, and fewer than half of these individuals remained free of alcohol problems over the long-term.[185]

Those who did achieve sustained moderated recoveries began with less severe alcohol problems and greater personal resources.[186] Given the greater difficulty of sustaining moderation in comparison to abstinence among those with AOD problem severity, it is not surprising that individuals choosing a moderation goal in treatment often shift this goal to abstinence at a later point in time.[187]

Persons with severe substance use disorders may achieve transient periods of reduction in AOD use and related problems, but this moderated pattern is more difficult to sustain than a pattern of sustained abstinence.[188] For persons who are alcohol dependent, where post-treatment abstinence at year one following treatment is associated with abstinence at year-three follow-up, a post-treatment moderate drinking outcome at year one is not associated with positive outcomes at year-three follow-up.[189] A sixty-year follow-up study of men with alcohol problems found that moderated drinking among those previously dependent upon alcohol tended to migrate toward abstinence or relapse to alcohol-related problems over time.[190]

The goal of addiction treatment continues to be the subject of debate,[191] and that debate will intensify if the treatment field extends its services to encompass a broader spectrum of problem severity—as

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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*, *88S*, S71-S84.

176. 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.

177. Hasin, D.S., Hatzenbuehler, M., Smith, S., & Grant, B.F. (2005). Co-occurring DSM-IV drug abuse in DSM-IV drug dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Drug and Alcohol Dependence, 80*, 117-123; Hoffmann, N.G., & Hoffmann, T.D. (2003). Construct validity for alcohol dependence as indicated by the SUDDS-IV. *Substance Use and Misuse, 38*, 293-306.

178. 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.

179. Ridenour, T.A., Cottler, L.B., Compton, W.M., Spitznagel, E.L., & Cunningham-Williams, R.M. (2003). Is there a progression from abuse disorders to dependence disorders? *Addiction, 98*, 635-644.

180. 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; Cunningham, J.A., Lin, E., Ross, H.E., & Walsh, G.W. (2000). Factors associated with untreated remission from alcohol abuse or dependence. *Addictive Behaviors*, *25*, 317-321. 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.

181. Miller, W.R. & Carroll, K.M. (2006). *Rethinking substance abuse: What the science shows, and what we should do about it.* NY: Guilford Press, pp. 296.

182. Schutte, K.K., Nichols, K.A., Brennan, P.L., & Moos, R.H. (2003). A ten-year follow-up of older former problem drinkers: Risks of relapse and implications of successfully sustained remission. *Journal of Studies on Alcohol*, *64*, 367-374.

183. 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.

184. Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

it has done in recent decades. Recovery from severe alcohol dependence is achieved primarily through complete and sustained abstinence, whereas the resolution of less severe alcohol problems is achieved primarily through altered drinking patterns, e.g., reduced frequency and quantity of drinking and altering drinking contexts.[192] Suggestions to use reduction in heavy drinking as a potential treatment goal and a treatment outcome measure[193] are increasing in the wake of studies finding that a significant portion of treated clients fail to achieve uninterrupted abstinence but dramatically reduce alcohol consumption and alcohol-related problems.[194]

The future of such suggestions will depend on how the treatment field ultimately defines itself. If the field claims its purview to include only severe substance dependence, then exclusively abstinence-based philosophies will continue to dominate the field. If the field claims cultural ownership of the whole spectrum of AOD-related problems (as it is recently prone to do), then we will likely see a broadening of treatment philosophies and methods appropriate and attractive to people with less severe alcohol or other drug problems—those who do not see themselves as "alcoholics" or "addicts" and those experiencing AOD problems that do not meet DSM-IV criteria for substance use disorders.

## Acute versus Chronic AOD Problems

The viability of AC models of intervention vary across clinical settings. In treatment settings that serve high-functioning populations presenting with low-to-moderate problem severity and high recovery capital, the AC model may well serve most of these clients—primarily because the client's own internal and external assets sustain the transition from recovery initiation to recovery maintenance. But as we shall soon see, the AC model fails critical performance benchmarks when treating clients with severe, complex, and chronic AOD problems. As the addiction treatment field evolves, there will be growing pressure to treat a broader spectrum of AOD problems. This will require two quite distinct changes: 1) the development of a broader service philosophy and service menu for those with less severe AOD problems, and 2) the development of models that allow addiction treatment programs to manage the long-term course of recovery from severe AOD dependence (to include continuity of support for the most severely impaired clients across multiple episodes of treatment). If the field continues to restrict its focus to severe AOD problems, a shift from AC to RM models of care is warranted. If the field broadens the scope of AOD problems within its purview, as it has tended to do, then it will need to distinguish those clients appropriate for the traditional AC model from those who need the sustained RM approach.

185. 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.

186. 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.

187. Hodgins, D., Leigh, G., Milne, R. & Gerrish, R. (1997). Drinking goal selection in behavioral self-management treatment of chronic alcoholics. *Addictive Behaviors, 22*, 247-255.

188. Schutte, K.K., Nichols, K.A., Brennan, P.L., & Moos, R.H. (2003). A ten-year follow-up of older former problem drinkers: Risks of relapse and implications of successfully sustained remission. *Journal of Studies on Alcohol*, *64*, 367-374; 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; Mann, K., Schafer, D.R., Langle, G., Ackermann, K., & Croissant, B. (2005). The long-term course of alcoholism, 5, 10, and 16 years after treatment. *Addiction*, *100*, 797-805.

189. 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*, *November*, 823-832.

190. Vaillant, G.E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98,* 1043-1051.

191. Owen, P., & Marlatt, G.A. (2001). Should abstinence be the goal for treatment? *The American Journal on Addictions, 10*, 289-295.

192. Sobell, M.B., & Sobell, L.C. (1995). Controlled drinking after 25 years: How important was the great debate? *Addiction*, *90*, 1149-1153.

193. Gastfriend, D.R., Garbutt, J.C., Pettinati, H.M., & Forman, R.F. (2007). Reduction in heavy drinking as a treatment outcome in alcohol dependence. *Journal of Substance Abuse Treatment, 33*, 71-80; McLellan, A.T. (2007). Reduced heavy drinking: A public health strategy and a treatment goal? *Journal of Substance Abuse Treatment*, *33*, 81-83.

194. 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.

In the next chapter we will explore who is attracted to and who has access to addiction treatment in the United States.

**TABLE 2: RECOVERY-LINKED SERVICE POPULATION PERFORMANCE MEASURES: WHO RECEIVES ADDICTION TREATMENT?**

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Problem Diversity | Ratio of dependence and abuse diagnoses<br>Percentage of clients with prior AOD treatment<br>Percentage of clients readmitted to a service organization or service unit in the year following discharge<br>Percentage of clients who are admitted for services within five years of onset of AOD problems<br>Percentage of clients with high recovery capital measured in dimensions of family stability, housing, employment, and pro-recovery social support |
| Response to Subclinical AOD Problems | Audit of service responses to clients determined not to meet DSM-IV diagnostic criteria<br>Audit of responses of those with lower problem severity to existing treatment methods, e.g., evidence of differential goal-setting and service menu choices by problem severity |
| Indigenous Support as Alternative to Treatment | Percentage of intakes referred to indigenous recovery support institutions and monitoring as an alternative to treatment admission |

# Chapter Six

## Treatment Attraction and Access

### ■ SUMMARY OF KEY POINTS ■

- Only 10% of persons meeting criteria for substance use disorders receive specialty-sector addiction treatment in any year, and only 25% of persons meeting criteria for substance use disorders will receive such specialized treatment in their lifetime.
- Multiple factors impede help-seeking for AOD problems: misperceptions of the severity of AOD problems, misjudgments regarding capability of self-resolving AOD problems, the cost of professional treatment; treatment-related social stigma, the lack of critical treatment supports such as transportation or day care, and resistance to complete abstinence as the only proffered treatment goal.
- The AC model **voluntarily** attracts only a small percentage of persons admitted to addiction treatment, with most persons entering treatment under external coercion at late stages of problem development.
- High pre-treatment drop-out rates (initial contact without service initiation—ranging from 25-50%) are linked to personal ambivalence, lack of geographical or financial access, waiting lists, and personal obstacles to participation.
- Promising practices related to increased attraction and access include social marketing of AOD problem-resolution options and successes, assertive models of outreach, lowered thresholds of engagement, interim services for those on waiting lists, short-term case management to enhance engagement, regular check-ups for those resisting immediate service entry, telephone prompts through the early engagement process, family mobilization strategies, extended clinical hours, and delivery of services in non-stigmatized sites.

The timing of treatment initiation for any chronic disease exerts a profound influence on the long-term course and outcome of the disorder. This principle may have special applicability to the addiction arena, where earlier treatment initiation is linked to an improved prognosis for long-term recovery and a lessening of harm inflicted on the family and the community. In this chapter, we will review

1) the ability of the acute-care system of addiction in the United States to attract individuals and families experiencing AOD problems, 2) the stage of problem development at which such assistance is sought, and 3) the ability of the treatment system to voluntarily attract individuals before forces in their environment conspire to coerce them into treatment. Strategies will also be catalogued that appear promising in shortening addiction careers and extending recovery careers.

## Ratio of Needed to Received Treatment

Only a small portion of those who need specialized addiction treatment in community and institutional populations receive such treatment,[195] and the percentage of persons with substance use disorders receiving treatment declined between 1992 and 2002.[196] At present, only 10.8% of U.S. citizens meeting DSM-IV criteria for *substance abuse or substance dependence* receive specialized addiction treatment each year,[197] and only 25% will receive an episode of such care in their lifetime.[198] Of the 23.6 million persons identified in the 2006 National Survey on Drug Use and Health meeting criteria for a substance use disorder, only 2.5 million persons received help at a specialized addiction treatment facility.[199]

Problems of attraction are magnified for:

- African Americans and Hispanic populations, who are less likely than White Americans to seek addiction treatment;[200]
- women, who are more likely to seek treatment for substance-related problems in primary health care or mental health service settings;[201] and
- those with less severe AOD problems.[202]

Of those who do enter specialty-sector addiction treatment, most do so 10 years after the onset of the substance use disorder.[203] Such delays have enormous implications for the personal, family, and social costs related to these disorders and for the long-term prognosis for recovery.

## Role of Coercion in Treatment Admission

Addiction treatment as currently constituted voluntarily attracts only a small portion of those who are experiencing severe substance use disorders in the United States. Referrals from coercive institutions to the nation's 13,200 specialized addiction treatment programs have risen dramatically

195. West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, *100*, 1036-1039.

196. 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. *Archives of General Psychiatry*, *64*(7), 830-842.

197. 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.

198. 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; 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; 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. *Archives of General Psychiatry, 64*(7), 830-842.

199. Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-32, DHHS Publication No. SMA 07-4293). Rockville, MD.

200. Wells, K.R., Klap, A. Koike, & Sherbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse and mental health care. *American Journal of Psychiatry, 158*(2), 2027-2032.

201. Greenfield, S.F., Brooks, A.J., Gordon, S.M., Green, C.A., Kropp, F., Kathryn McHugh, R., Lincoln, M., Hien, D., & Miele, G.M. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and Alcohol Dependence*, *86*, 1-21; Weisner, C., & Schmidt, L. (1992). Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association, 268*(14), 1872-1876; Schober, R., & Annis, H.M. (1996). Barriers to help-seeking for change in drinking: A gender-focused review of the literature. *Addictive Behaviors*, *21*, 81-92.

202. Tucker, J.A., & Gladsjo, J.A. (1993). Help-seeking and recovery by problem drinkers: Characteristics of drinkers who attended Alcoholics Anonymous or formal treatment or who recovered without assistance. *Addictive Behaviors*, *18*, 529-542; Tucker, J.A., Vuchinich, R.E., & Rippens, P.D. (2004). A factor analytic study of influences on patterns of help-seeking among treated and untreated alcohol dependent persons. *Journal of Substance Abuse Treatment*, *26*, 237-242.

203. 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. *Archives of General Psychiatry*, *64*(7), 830-842.

in the past two decades. Referrals from the criminal justice system increased from 38% of total referrals in 1990 to 59% of referrals in 2004. During the same time period, referrals from welfare and child protection systems increased from 8% to 16%. Addiction treatment's disconnection from mainstream health care is indicated by the fact that only 3% of referrals to addiction treatment come from hospitals or physicians.[204]

Those who seek specialized addiction treatment generally do so at late stages of problem development[205] and do so primarily under the influence of external coercion via the threat of alternative consequences (e.g., jail, divorce, loss of custody of children, loss of employment, loss of government benefits) from families, the criminal justice system, professional licensing bodies, employers, the public welfare system, the child protection system, and educational institutions.[206]

The point here is not that external coercion into treatment is inherently bad in terms of outcomes. Those coerced into treatment have recovery outcomes as good as or better than those entering treatment without an identifiable coercive agent.[207] The point is that coercion reflects intervention at a very late stage of problem development.

## Reasons for Not Seeking Treatment

Persons experiencing AOD problems identify the following reasons for not seeking treatment:

- reluctance to give up the drug;
- reluctance to admit the need for help;
- perception that the problem is not severe enough to warrant treatment;
- perception that they can manage the problem by themselves, without professional help;
- lack of knowledge about treatment;
- inability to afford treatment;
- belief that treatment would not be helpful;
- lack of transportation or day care; and
- scheduling difficulties.[208]

204. McLellan, A.T. (2006). *Addiction is changing: How changes in systems and customers may affect the Betty Ford Institute.* Presentation to Betty Ford Institute Executive Council, February, Rancho Mirage, CA.

205. 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.

206. Institute of Medicine. (1990). *Treating Drug Problems, Vol 1.* Washington, D.C.: National Academy Press; Wild, T.C. (2006). Social control and coercion in addiction treatment: Towards evidence-based policy and practice. *Addiction*, *101*, 40-49.

207. Miller, N.S., & Flaherty, J.A. (2000). Effectiveness of coerced addiction treatment (alternative consequences): A review of the clinical research. *Journal of Substance Abuse Treatment*, *18*, 9-16; Kelly, J.F., Finney, J.W., & 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.

208. Cunningham, J.A., Sobell, L., Sobell, M., Agrtawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors*, *18*, 347-353; 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; Tucker, J.A., Vuchinich, R.E., & Rippens, P.D. (2004). A factor analytic study of influences on patterns of help-seeking among treated and untreated alcohol dependent persons. *Journal of Substance Abuse Treatment*, *26*, 237-242; Ellingstad, T.P., Sobell, L.C, Sobell, M.B., Eickleberry, L., & Golden, C.J. (2006). Self-change: A pathway to cannabis abuse resolution. *Addictive Behaviors*, *31*, 519-530; Wechsberg, W.M., Zule, W.A., Riehman, K.S., Luseno, W.K., & Lam, W.K. (2007). African-American crack abusers and drug treatment initiation: Barriers and effects of a pretreatment intervention. *Substance Abuse Treatment, Prevention and Policy, 2*(10), 1-18.

Fear of social stigma also discourages help-seeking,[209] and there is evidence that such fear is justified. The majority of people entering addiction treatment report that: 1) they have heard disparaging and offensive comments about people who have been treated for addiction, 2) it was rare for family and friends to provide support for their decisions to enter treatment, and 3) they worry about what others will say about their having gone to treatment.[210] The role stigma plays in discouraging help-seeking may be particularly intense for those dependent upon drugs that are the targets of cultural drug panic (e.g., the current social alarm regarding methamphetamine) and those who have failed to remain abstinent following previous treatment.[211]

There are also obstacles to the attraction of people to specialized addiction treatment at lower levels of problem severity—obstacles that include the treatment system's singular and pre-defined goal of abstinence, fear of being labeled an alcoholic or addict, social stigma, and the fear that the time required for treatment will disrupt family and professional responsibilities.[212]

## Access to Treatment

Rapid access to addiction treatment influences treatment outcomes.[213] Persons who seek treatment and immediately receive it have better recovery outcomes than those who seek treatment and either fail to receive treatment or receive delayed treatment.[214] In general, the longer the delay in entering addiction treatment, the greater the dropout rate.[215] Those who drop out of treatment before it begins have worse outcomes than those who initiate and stay in treatment.[216] One measure of access is the percentage of persons admitted for acute detoxification who are linked to ongoing treatment. Such linkage is important in that detoxification by itself has little role in recovery initiation. Those who experience treatment following detoxification have much better long-term recovery outcomes than those who only undergo detoxification.[217] A study of such linkage processes revealed that only 49% of persons discharged from detox had any continuing care services and that those who did received only an average of 3.5 visits following discharge.[218]

209. Cunningham, J.A., Sobell, L., Sobell, M., Agrtawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors*, *18*, 347-353.

210. Luoma, J.B., Twohig, M.P., Waltz, T., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors*, *32*, 1331-1346.

211. Semple, S.J., Grant, I., & Patterson, T.L. (2005). Utilization of drug treatment programs by methamphetamine users: The role of social stigma. *The American Journal on Addictions*, *14*, 367-380.

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213. Moos, R.H., & Moos, B.S. (2003). Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorders. *Addiction*, *98*, 325-337.

214. 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.

215. 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.

216. Gottheil, E., Sterling, R.C., & Weinstein, S.P. (1997b). Pretreatment dropouts: Characteristics and outcomes. *Journal of Addictive Diseases*, *16*, 1-14.

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## Obstacles to Access

Similar to attraction, treatment access is inhibited by:

- the ambivalence that those with substance use disorders experience when they consider altering their relationship with alcohol and other drugs (and the absence of system-wide pre-treatment engagement services to enhance motivation for change);
- the lack of geographically accessible, financially affordable treatment services;
- long waiting lists to be admitted to addiction treatment (and high—25-50%— dropout rates of persons on such lists); and
- personal/family/environmental obstacles to treatment initiation (and the lack of case management services to resolve such obstacles).[219]

These factors combine to generate pre-treatment dropout rates (people who schedule but fail to show for their first appointment) from 25-50%.[220]

Financial obstacles to treatment include a lack of health insurance coverage, insurance coverage that does not include addiction treatment, insurance with high deductibles, insurance with limits on length of treatment or number of episodes of treatment, and public service providers requiring an advance on fees prior to service initiation.[221] A recent study reported that lack of insurance was not an obstacle for admission into addiction treatment[222]—a partial testament to the widespread availability of publicly funded addiction treatment—but this finding does not extend to all client groups and communities, particularly ethnic communities.[223]

Persons with disabilities face significant obstacles (e.g., parking, restroom facilities, lack of accessible hallways and doors, absence of ramps and elevators, etc.) in accessing specialized addiction treatment, in spite of research findings that persons with disabilities are at equal or increased risk of developing AOD-related problems.[224] Women face greater obstacles entering addiction treatment than do men (e.g., greater problem severity and complexity, stigma, lack of financial resources, child care responsibilities, fear of losing custody of children, lack of support for treatment involvement from intimate partners or family members, and lack of transportation).[225] As a result, women seek specialized addiction treatment less often than do men[226] and are more likely to seek help for AOD problems in medical or psychiatric service settings.[227]

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219. Little Hoover Commission. (2003, March). *For our health and safety: Joining forces to defeat addiction*. State of California. Retrieved from http://www.adp.cahwnet.gov/report169.pdf; 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; Hser, Y.I., Maglione, M., Polinsky, L, & Anglin, M.D. (1998). Predicting drug treatment entry among treatment-seeking individuals. *Journal of Substance Abuse Treatment, 15*(3), 213-220; 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.

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226. Schober, R., & Annis, H.M. (1996). Barriers to help-seeking for change in drinking: A gender-focused review of the literature. *Addictive Behaviors*, *21*, 81-92.

227. Weisner, C., & Schmidt, L. (1992). Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association, 268*(14), 1872-1876.

African American crack cocaine users experience obstacles related to attraction and access that can be reduced through special pre-treatment interventions.[228]

## Attraction, Access, and the Management of Chronic Disease

Issues of attraction and access differ across acute and chronic illnesses. Help-seeking for acute disorders does not have to be sold, because the immediacy and severity of distress often send one running for help even where service access is a problem (as any reader will know who has recently visited a hospital emergency room). In contrast, the often slow and insidious nature of chronic illnesses can make it difficult to decide when, if ever, to seek help until the onset of an acute episode of great severity.

Access to care for chronic illness is also not an issue of point-in-time access, as it is for acute illness. Chronic illness requires a safety net of long-term access to ensure stabilization of acute flare-ups within the prolonged ebb and flow of symptoms. In managing chronic disorders other than addiction, patients are encouraged to seek help early to stabilize such flare-ups and are welcomed back into service and praised for these timely decisions. In contrast, those seeking re-entry into addiction treatment are often shamed, treated with contempt (e.g., the source of such pejorative terms as "frequent flyer" and "retread"), and potentially denied admission based on their history of prior treatments.

The following principles, drawn from available studies and the author's observations, underscore the importance of attraction and access for severe and prolonged substance use disorders.

1. The earlier the age of onset of the first treatment episode, the shorter the addiction career and the greater the prognosis for recovery:[229] Those who enter treatment in the first decade of use shorten their addiction career by as much as 50%.[230]
2. The earlier the initiation of treatment, the greater the level of recovery capital available to aid the transition from recovery initiation to stable, long-term recovery maintenance.
3. The greater the social stigma attached to AOD problems, the later the onset of help-seeking behavior.
4. Addiction careers lengthen and become more severe and complex in tandem with increases in treatment-related social stigma and higher thresholds of service engagement; recovery careers begin earlier and lengthen as treatment-related social stigma declines and thresholds of service engagement are lowered.

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228. Wechsberg, W.M., Zule, W.A., Riehman, K.S., Luseno, W.K., & Lam, W.K. (2007). African-American crack abusers and drug treatment initiation: Barriers and effects of a pretreatment intervention. *Substance Abuse Treatment, Prevention and Policy, 2*(10), 1-18.

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5. The earlier the stage of problem development at which treatment begins, the less the long-term injury to families and communities.
6. Access of family and friends to recovery-focused information and support can enhance their own health and speed help-seeking of those dependent upon alcohol and other drugs.[231]
7. Reaching a broader population of persons in need of treatment services is predicated on understanding the multiple and diverse reasons people seek changes in their relationships with alcohol and other drugs.[232]

## Treatment Attraction and Access:
## Potential Strategies to Enhance Recovery Outcomes

- Disseminate data on drinking and drug-use norms across age, ethnic, and gender groups.[233]
- Conduct public education strategies aimed at reducing stigma attached to seeking treatment for substance use disorders.[234]
- Take inventory of policies and service practices that may contribute to the stigma experienced by those seeking addiction treatment.[235]
- Provide adolescents access to programs that do not require parental consent for service initiation.[236]
- Target youth high in sensation seeking with educational and early intervention strategies as they move away from home into community and college environments.[237]
- Target females (of all races) and Black males aged 18-29 for special outreach, education, and intervention programs.[238]
- Use a choice philosophy related to abstinence vs. moderation goals.[239]
- Explore service models that bridge the polarized debate between abstinence-oriented addiction treatment and harm-reduction strategies.[240]
- Provide specialized treatment and recovery support services for persons with disabilities.[241]
- Offer treatment services through non-stigmatized service sites (e.g., mainstream health care and counseling agencies).[242]

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234. Luoma, J.B., Twohig, M.P., Waltz, T., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*, 1331-1346.

235. Luoma, J.B., Twohig, M.P., Waltz, T., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*, 1331-1346.

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241. For an example of such a service, see Alvarez, J., Adebanjo, A.M., Davidson, M.K., Jason, L.A., & Davis, M.I. (2006). Oxford House: Deaf-affirmative support for substance abuse recovery. *American Annals of the Deaf, 151*(4), 418-421.

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- Provide telephone counseling of patients screened for alcohol use disorders at primary health care clinics.[243]
- Provide early intervention services to those with AOD problems through sexually transmitted disease clinics.[244]
- Use telecounseling or televideo counseling to reach those with AOD problems in rural areas.[245]
- Offer free, mailed self-help materials and computer-based and Internet-based personal assessment and feedback for people concerned about their alcohol or drug use.[246]
- Provide ambivalent marijuana users personalized feedback in the context of a series of marijuana check-ups.[247]
- Offer free self-evaluation and self-help materials combined with a free personal evaluation with feedback.[248]
- Work with families via "encourage to change" strategies for substance-impacted adults[249] and adolescents.[250]
- Engage those in need of services via drop-in centers[251] or street outreach programs.[252]
- Engage and link opiate addicts to detox via needle exchange programs.[253]
- Deliver coupons for free detoxification and treatment via street outreach workers.[254]
- Disseminate information to the general population and opiate user populations to counter common myths related to methadone and methadone maintenance.[255]
- Build strong linkages to primary treatment and primary recovery support services from modalities that in isolation have minimal effect on long-term recovery outcomes (e.g. detoxification).[256]
- Utilize early engagement strategies (e.g., assertive waiting list management, role induction activities, interim service contact using motivational interviewing, case management, brief family interventions, and contingency management).[257]
- Train all reception staff in warm welcoming techniques
- Provide escort services and incentive payments for movement from detoxification to primary treatment.[258]
- Use telephone prompts to re-engage clients who miss their first appointment.[259]
- Extend clinic hours and streamline intake procedures.[260]

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249. Copello, A.G., Velleman, R.D., & Templeton, L.J. (2005). Family interventions in the treatment of alcohol and drug problems. *Drug and Alcohol Review*, *24*, 369-385; Meyers, R.J. & Smith, J.E. (1995). *Clinical guide to alcohol treatment: The community reinforcement approach*. New York: Guilford Press; Meyers, R., Miller, W., Hill, D., & Tonigan, J. (1999). Community reinforcement and family training (CRAFT): Engaging unmotivated drug users in treatment. *Journal of Substance Abuse*, *10*, 291-308.

250. Waldron, H.B., Kern-Jones, S., Turnerm C.W., Peterson, T.R., & Ozechowski, T.J. (2007). Engaging resistant adolescents in drug abuse treatment. *Journal of Substance Abuse Treatment*, *32*, 133-142.

251. Lundgren, L., Amodeo, M., Schneider, R., Ellis, M., Fitsgerald, T., & Stevens R. (1999). African-American injection drug users: Association between pre-treatment services and entry into and completion of detoxification. *Evaluation and Program Planning, 22*, 259-267.

252. Brown, B.S., & Needle, R.H. (1994). Modifying the process of treatment to meet the threat of AIDS. *The International Journal of the Addictions*, *29*(13), 1739-1752; Rowden, D.W., Dorsey, P.E., Bullman, S., Lestina, R.P., Han, C., & Herrel, J.M. (1999). HIV outreach for hard-to-reach populations: A cross-site perspective. *Evaluation and Program Planning*, *22*, 251-258.

## TABLE 3: RECOVERY-LINKED SERVICE POPULATION PERFORMANCE MEASURES: ATTRACTION AND ACCESS

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Attraction | Average time from onset of use (or problem onset) to first treatment admission. |
| | Percentage of clients without prior AOD specialty treatment |
| | Percentage of clients entering treatment not under external coercion |
| | Average time from onset of use (or problem onset) following treatment discharge to readmission |
| | Comparison of demographics of treatment admissions with demographics of local AOD-related casualty data, e.g., deaths, ER admissions, arrests |
| Access | Average number of clients per month on waiting lists for service entry |
| | Average length of time on waiting lists before service initiation |
| | Average length of time from intake to first appointment |
| | Percentage of clients who drop out between first call and first appointment |
| | Average length of time between lapse, relapse, and readmission to treatment |

253. Wood, E., Tyndall, M.W., Zhang, R., Montaner, J.S.G., & Keer, T. (2007). Rate of detoxification service use and its impact among a cohort of supervised injection facility users. *Addiction*, *102*, 916-919.

254. Schuster, C.R. (1988). Intravenous drug use and AIDS prevention. *Public Health Reports*, *103*(3), 261-266.

255. Kayman, D.J., Goldstein, M.F., Deren, S., & Rosenblum, A. (2006). Predicting treatment retention with a brief ìOpinions about Methadoneî scale. *Journal of Psychoactive Drugs*, *38* (1), 93-100.

256. Institute of Medicine. (1990). *Treating Drug Problems, Vol 1*. Washington D.C.: National Academy Press.

257. He, H., Stark, M., Fleming, D., Gould, J., Russell-Alexander, Y., & Weir, B. (1996). Facilitation into drug treatment or self-help among out-of-treatment IDUs in Portland: You can lead a horse to water, but… *Journal of Drug Issues*, *26*, 649-661; Gottheil, E., Sterling, R.C., & Weinstein, S.P. (1997a). Outreach engagement efforts: Are they worth the effort? *American Journal of Drug and Alcohol Abuse*, *23*, 61-66; Rapp, R.C., Otto, A.L., Lane, D.T., Redko, C. McGatha, S., & Carlson, R.G. (2008). Improving linkage with substance abuse treatment using brief case management and Motivational Interviewing. *Drug and Alcohol Dependence*, *94*, 172-182; O'Farrell, T.J., Murphy, M., Alter, J. & Fals-Stewart, W. (2008). Brief family treatment intervention to promote continuing care among alcohol-dependent patients in inpatient detoxification: A randomized pilot study. *Journal of Substance Abuse Treatment, 34*, 363-369.

258. Chutuape, M.A., Katz, E.C., & Stitzer, M.L. (2001). Methods for enhancing transition of substance abuse patients from inpatient to outpatient treatment. *Drug and Alcohol Dependence*, *61*, 137-143.

259. Gottheil, E., Sterling, R.C., & Weinstein, S.P. (1997a). Outreach engagement efforts: Are they worth the effort? *American Journal of Drug and Alcohol Abuse*, *23*, 61-66.

260. SAMHSA News. (2007). Reduced waiting time improves treatment access, retention. *15*(6), 1-2.

# Chapter Seven

## Screening, Assessment, and Level-of-Care Placement

### ■ SUMMARY OF KEY POINTS ■

- Early screening and brief interventions for AOD problems are effective strategies for reaching persons with AOD problems who are involved in non-specialized community-based service settings, particularly primary health care settings.
- RM models of assessment differ from the AC models in key dimensions. Assessment processes: are global rather than categorical; define the individual, family, and community as the unit of assessment rather than just the individual; are asset-based rather than problem- or deficit-based; and constitute a continuing process rather than a point-in-time (intake) event.
- Where level-of-care decisions in the AC model focus primarily on problem severity and complexity, such decisions in the RM model are heavily influenced by the assessment of personal, family, and community recovery capital.
- Promising practices related to screening, assessment, and placement include AOD problem screening in primary care settings, Internet-based screening services, use of standardized global assessment instruments, family-focused assessment protocols, and regular recovery community resource mapping.

### Screening

Effective screening and early interventions for acute illnesses are often precluded by the rapid onset and progression and short course of such disorders, but the gradual onset and prolonged course of most severe substance use disorders provide windows of opportunity for screening and early intervention.

Considerable progress has been made in developing quick screening instruments for alcohol and other drug-related problems. The alcohol screening instruments include the CAGE questionnaire, the Alcohol Use Disorders Identification Test (AUDIT), the TWEAK questionnaire, the T-ACE questionnaire, the Rapid Alcohol Problems Screen (RAPS4), the Michigan Alcoholism Screening Test (MAST), the Fast Alcohol Screening Test (FAST), the Paddington Alcohol Test, the Self-Administered

Alcoholism Screening Test (SAAST), the Young Adult Alcohol Problems Screening Test (YAAPST), the College Alcohol Problems Scale (CAPS-r), and the Rutgers Alcohol Problem Index (RAPI). Instruments used to evaluate those arrested for driving under the influence of alcohol also include the Mortimer-Filkins, the Driver Risk Inventory (DRI-II), the Adult Substance Use and Driving Survey (ASUDS), the MacAndrews Alcoholism Scale-Revised (MAC-R), the Substance Abuse Life Circumstances Evaluation (SALCE) , the Substance Use Disorder Diagnostic Schedule (SUDDS), and the Global Appraisal of Individual Need Short Screener (GAIN-SS). There are also laboratory tests that provide objective markers for alcohol problems, including elevated levels of gamma-glutamyl transferase (GGT), carbohydrate-deficient transferase (CDT), and mean corpuscular volume (MCV). Fatty acid ethyl esters (FAEEs) also constitute markers of prenatal alcohol exposure.[261]

Drug screening instruments include the Drug Abuse Screening Test (DAST), Drug Use Screening (DUS), Drug Use Screening Inventory-Revised (DUSI-R), the Addiction Potential Scale (APS), the Adverse Consequences of Substance Use Scale (ACSUS), the Simple Screening Instrument for Substance Abuse (SSI-SA), and the Global Appraisal of Individual Need Short Screener (GAIN-SS).

Population-wide screening and targeted screening of at-risk groups are highly effective strategies for the community-wide management of chronic health disorders, as indicated by the growing presence of online screening tools and health screening at health fairs and other community events. Screening of alcohol and drug use and related problems outside the addiction treatment arena has six primary goals:

1) helping individuals and their health care providers identify and assess the magnitude of an individual's risk for future development of a substance use disorder;
2) devising prevention strategies through which at-risk individuals can prevent or delay onset of substance use disorders by avoiding a priming dose of symptom activation;
3) encouraging the development of problem-solving and self-management strategies at early stages of problem development;
4) providing professional supports to facilitate the resolution of early-stage problems;
5) assertively linking individuals with more advanced problems to further professional assessment and the potential provision of specialized treatment and recovery support services; and

261. National Institute on Alcohol Abuse and Alcoholism. (2002). Screening for alcohol problems-An update. *Alcohol Alert, 56.*

6) identifying those individuals whose AOD-related problems pose substantial threats to public health and public safety, and who may require sustained external monitoring to minimize these risks (e.g., the "hard-core drinking driver").[262]

Substantial progress is being made in increasing early screening for substance use disorders in the United States. The Center for Substance Abuse Treatment has invested considerable resources in its Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative. This initiative has focused on screening individuals at risk for substance-related problems in physicians' offices, hospitals, and educational institutions, and in mental health and other social service settings. To-date (August, 2007), more than a half million individuals have been screened through this initiative.

Early problem identification, encouragement of self-management strategies (via motivational interviewing, goal setting, education, and skills training), peer-based support, and professional monitoring are important strategies within the recovery management model. These strategies are intended to shrink the total population of persons experiencing severe substance use disorders and, where problems already exist, to lower the aggregate severity of these problems. As with most chronic disorders, the principle is a clear one: the earlier the stage of intervention, the better the prognosis for long-term recovery.

## Categorical versus Global Assessment

Assessment and treatment planning constitute a mainstream component of the AC model of addiction treatment in the United States.[263] Mainstream assessment procedures have several distinguishing characteristics.

Assessment procedures in the AC model are categorical rather than global, with a singular focus on the primary problem that has generated the present crisis. As in a hospital emergency room, the focus is on the wounded part, not the whole person. Similarly, little depth of information is collected on the family and social environment in which AOD problems are nested and in which recovery efforts will succeed or fail. Information gathered on the individual is based almost exclusively on self-report and focused on AOD use patterns, consequences, and past resolution efforts. Calls for more rigorous assessments are growing, and comprehensive assessments are increasing within American addiction treatment (from 37% in 2000 to 63% in 2005).[264]

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262. White, W., & Gasperin, D. (2007). The ìhard core drinking driverî: Identification, treatment and community management. *Alcoholism Treatment Quarterly*, *25*(3), 113-132.

263. Alexander, J.A., Nahra, T.A., Lemak, C.H., Pollaco, H., & Campbell, C.I. (2008). Tailored treatment in the outpatient substance abuse treatment sector: 1995-2005. *Journal of Substance Abuse Treatment*, *34*, 282-292.

264. Alexander, J.A., Nahra, T.A., Lemak, C.H., Pollaco, H., & Campbell, C.I. (2008). Tailored treatment in the outpatient substance abuse treatment sector: 1995-2005. *Journal of Substance Abuse Treatment*, *34*, 282-292.

Intervention options are restricted by the scope of the assessment process. More than 45% of clients entering addiction treatment do not receive physical exams as part of the assessment or admission process, only 45% receive any primary health care as part of their treatment, few receive a comprehensive mental status review, and only 29% receive any collateral mental health services.[265] The singular focus on AOD problems is challenged by the fact that individuals and families presenting with multiple, complex problems and prolonged service careers within categorically segregated service systems are increasingly the norm in public and private addiction treatment programs.[266]

The course of prolonged AOD problems is significantly influenced by the presence and severity of collateral problems, the family and extended family network, and the client's natural physical and social environment. Where two or more problems co-exist, remission of either problem is often contingent upon remission of the other. For example, studies of the long-term effects of major depression on the course of alcoholism reveal that the remission of each condition is linked to remission of the other.[267] The whole scope of personal, family, and environmental problems must be assessed for long-term recovery planning.

The trend in the emerging recovery management model is toward the use of comprehensive (global) assessment instruments and multiple assessment media.[268] There is also a shift from viewing the individual as the unit of service to viewing the "family," kinship network, and community (as defined by the client) as the unit of assessment and intervention.

## Deficit-based versus Asset-based Assessment

Assessment procedures in the AC model of addiction treatment also tend to be pathology-focused. Assessment data collection procedures are designed to generate a problem list, which is then used to generate a treatment plan. Given the growing severity, complexity, and chronicity of problems presented by clients seeking addiction treatment, such pathology-focused assessment interviews can be demoralizing to clients, families, and staff. Missing from current assessment protocols is an evaluation of personal, family, and community recovery capital. Recovery capital was defined earlier as including all the intrapersonal, interpersonal, and community resources that can be brought to bear on the initiation and maintenance of recovery.[269]

A primary function of screening and assessment procedures in addiction treatment is to make level-of-care decisions. Most patient placement classification systems rely primarily upon problem

265. 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.

266. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems; Hser, Y.I., Grella, C.E., Hubbard, R.L., Hsieh, S., Fletcher, B.W., Brown, B.S., & Anglin, M.D. (2001). An evaluation of drug treatments for adolescents in 4 US cities. *Archives of General Psychiatry, 58*, 689-695.

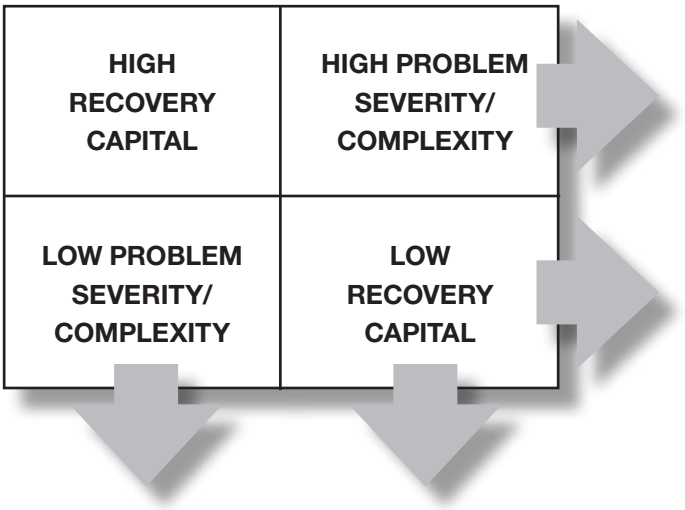
267. Hasin, D.S., Wei-Yuan, T., Endicott, J., Mueller, T., Coryell, W., & Keller, M. (1996). The effects of major depression on alcoholics. *The American Journal of Addictions, 5*(2), 144-155.

268. 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.

269. Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment.* New York: New York University Press.

severity and complexity data to dictate a particular level of care. The general assumption is that, the greater the problem severity and complexity, the greater the restrictiveness and potential duration of treatment. But comprehensive assessments of recovery capital can alter such decisions considerably (See figure below).

**FIGURE 2: PROBLEM SEVERITY/RECOVERY CAPITAL MATRIX**




Here are two examples. Many individuals with moderate-to-high problem severity might warrant inpatient placement of some duration, but those who bring high levels of recovery capital may initiate and sustain recovery, receiving much lower levels of care and lower intensity of post-treatment monitoring. In contrast, an individual at early stages of addiction with many vulnerability factors (e.g., family history of AOD problems, early age of onset, traumatic victimization) and extremely low personal recovery capital who also lives in a community lacking significant recovery support resources may warrant placement at a high level of care and require higher-intensity post-treatment monitoring

and support. The assessment of personal, family, and community recovery capital is essential to long-term recovery management.[270]

## Point-in-time versus Continual Assessment

Current AC Model assessment procedures constitute a single point-in-time evaluation that is completed as part of the initial intake and service-planning process. Such procedures are appropriate for acute disorders that resolve themselves naturally or through brief intervention, but are quite inadequate for conditions whose symptoms ebb and flow over a protracted period of time and are exacerbated by the tandem ebb and flow of collateral problems.

There is a growing body of scientific literature positing stage theories of addiction recovery.[271] These studies suggest that:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time-dependent process.
- Within each stage of recovery are developmental tasks, skills to be mastered, certain perspectives to be developed, and certain issues to be addressed before movement to the next stage can occur.
- The nature of the developmental stages of recovery is shaped by the characteristics of the individual; the nature, intensity, and duration of drug use; and the social milieu within which recovery occurs.
- Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
- Treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent within each individual's current stage of recovery.
- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

Some stages-of-change theories have come under recent attack for their lack of empirical foundation,[272] but virtually all long-term studies of recovery acknowledge recovery as a stage-dependent

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270. White, W. & Cloud, W. (in press). Recovery capital: A primer for addiction professionals. *Counselor*.

271. DeLeon, G. (1996). Integrative recovery: A stage paradigm. *Substance Abuse, 17*(1), 51-63; DeLeon, G. (2007). Therapeutic community treatment in correctional settings: Toward a recovery-oriented integrated system. *Offender Substance Abuse Report, 7*(6), 81-96; Frykholm, B. (1985). The drug career. *Journal of Drug Issues, 15*, 333-346; Wadorf, 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; Shaffer, H.J., & Jones, S.B. (1989). *Quitting cocaine: The struggle against impulse*. Lexington, MA: Lexington Books; Klingemann, H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of Addiction, 86*, 727-744; Prochaska, J., DiClimente, C., & Norcross, J. (1992). In search of how people change. *American Psychologist, 47*, 1102-1114.

272. West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, *100*, 1036-1039.

process. If we posit that long-term recovery is marked by such stages and that service needs change across these stages, then how can assessment be limited to an intake activity? In the chronic disease model, assessment is a continual process, and any significant change in the status of a client signals formal re-evaluation.

### Assessment of Family and Community Recovery Capital

Developing recovery-oriented systems of care requires the long-term development and mobilization of community recovery capital. This calls for a formal assessment of community recovery assets as well as such assets of individuals and families. We will discuss this issue of community recovery capital in more depth later in the monograph.

### Screening and Assessment: Potential Strategies to Enhance Recovery Outcomes

- Provide screening, brief intervention, and linkage to treatment on a community-wide basis.[273]
- Encourage the availability of online screening and self-guided recovery management materials.[274]
- Define the "family" (as defined by the client) as the unit of assessment.
- Use a standardized global assessment instrument such as the Addiction Severity Index (ASI) or the Global Appraisal of Individual Needs (GAIN).
- Use assessment media beyond those involving self-report, e.g., physical exams, laboratory tests, criminal records verification.
- Use a strengths-based assessment process such as the ETP Strengths Assessment.[275]
- Redefine assessment as a continual process and conduct regular within-treatment assessment updates, including within-treatment indicators that trigger formal multi-disciplinary reassessment.[276]
- Regularly survey community recovery resources.

273. National Institute of Alcohol Abuse and Alcoholism. (2002). Screening for alcohol problems—An update. *Alcohol Alert, 56*; National Institute of Alcohol Abuse and Alcoholism. (2005). Screening for alcohol use and alcohol related problems. *Alcohol Alert, 65*.

274. Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

275. Siegal, H.A., Rapp, R.C., Kelliherm 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.

276. Brown, T.G., Topp, J., & Ross, D. (2003). Rationales, obstacles, and strategies for local program monitoring systems in substance abuse treatment settings. *Journal of Substance Abuse Treatment*, *24*, 31-42.

## TABLE 4: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES: SCREENING, ASSESSMENT, AND LEVEL-OF-CARE PLACEMENT

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Screening | Number of screenings performed per quarter<br>Number of hits per quarter on local screening website<br>Number of training sessions per quarter on screening for other health and human service professionals |
| Individual/family Assessment | Percentage of intakes that include family collateral interview<br>Percentage of parent assessments that include child assessment data |
| Assessment of Community Recovery Capital | Date of last community recovery needs assessment and recovery resource mapping survey |

# Chapter Eight

## Composition of the Service Team

### ■ SUMMARY OF KEY POINTS ■

- The extension of AC models of addiction treatment to RM models entails increased involvement of medical, psychiatric, and other allied professionals and the development of peer-based recovery support services.
- There are growing numbers of individuals and families with long, complex service careers within multiple systems who, despite the massive investment of dollars in crisis stabilization, exhibit minimal progress towards long-term recovery.
- RM models of care emphasize multi-agency models of intervention and embrace a larger goal of breaking intergenerational cycles of problem transmission, thus providing a framework for the integration of primary prevention, early intervention, treatment, and long-term recovery support strategies.
- Promising practices that enhance service team composition include providing primary medical/psychiatric care in tandem with addiction treatment, the use of recovery coaches to provide continuity across levels of care, increased use of volunteers, and the creation of multi-agency, multi-disciplinary service teams.

The primary workforce of the specialized field of addiction treatment is made up of certified addiction counselors and non-certified direct service personnel. As the field is currently constituted, most individuals undergoing addiction treatment in the United States will spend little face-to-face time with physicians, nurses, psychologists, or social workers.[277] Many clients will also undergo addiction treatment without significant involvement of other helping organizations in their care, although this has changed recently with the growing trend toward co-sponsorship and co-location of service programs. The shift from an exclusively acute-care to a more sustained recovery management model of addiction treatment alters staffing and organizational configurations in three critical ways.

277. 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.

## Medical/Psychiatric and Allied Professional Staff

The acute and often undiagnosed health problems of persons presenting for addiction treatment and the high post-treatment morbidity and mortality rates (later summarized in Chapter Fourteen) warrant a more medicalized system of assessment and ongoing health care management. We will discuss some options for integrating primary health care and addiction treatment in Chapter Eleven. The issue of medical staff inclusion is not limited to the scope of medical needs at the time of admission, but also includes the potential role of medical staff as allies in the long-term recovery process. The issue is the same for psychologists, social workers, and other allied professionals.

There is growing evidence that the period of greatest need for these professionals may be following the period of initial sobriety. This is confirmed by studies finding that emotional distress in recovery peaks, not in the earliest days and weeks of recovery, but between one and three years of recovery.[278] Studies are also confirming the destabilizing effects that recovery exerts on the family as a system.[279] Growing interest in the personality reconstruction and emotional/spiritual growth that occurs in late (often after 5 years of sobriety) stages of recovery,[280] and the complete lack of research on the dynamics of late-stage relapse (relapse following 10 or more years of continuous sobriety), raise the possibility that the greatest contributions of traditionally trained professionals to the recovery process may be in facilitating these transitional stages of later recovery.

## Peer-based Recovery Support Services (P-BRSS)

P-BRSS in the addictions arena are part of a long "wounded healer" tradition positing that those who have experienced and survived an ordeal may have special insights available to those facing similar circumstances.[281] Persons providing P-BRSS, rather than being legitimized through traditionally acquired educational credentials, tend to be legitimized based on *experiential knowledge and experiential expertise.*[282]

> *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*

278. 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.

279. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

280. Larsen, E. (1985). *Stage II recovery: Life beyond addiction.* New York: HarperCollins Publishers; Tessina, T. (1991). *The real thirteenth step: Discovering confidence, self-reliance and autonomy beyond the 12-Step programs.* Los Angeles, CA: Jeremy P. Tarcher, Inc.; Picucci, M. (2002). ìAn Interview with Dr. Michael Picucciî and iTerms and Definitions.î Retrieved on February 20, 2008 from http://www.stagedrecovery.com

281. Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine, 75*, 1-36.

282. Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*(3), 443-456.

*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.*[283]

The history of 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 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; detoxification technicians, residential aids, outreach workers, and case managers (1970s-1990s); and, more recently, "recovery coaches," "recovery mentors," and "recovery support specialists."[284]

Peer-based services have expanded under the influence of CSAT's Recovery Community Services Program and Access to Recovery program, and through state and urban treatment system-transformation efforts that are systematically including P-BRSS as part of a reconfigured continuum of addiction treatment services care. The expansion and positive evaluation of P-BRSS within the mental health field[285] and the growth of treatment programs for co-occurring substance use and psychiatric disorders are speeding the expansion of P-BRSS in the addiction field.[286] A distinguished addiction treatment researcher recently reflected on the potential value of such natural supports.

*There is no compelling conceptual reason to distinguish between the influence of an AA sponsor, a source or partner, and a relative or friend, versus that of a counselor or psychotherapist on an addicted individual. The cognitive and social processes that underlie the resolution of addictive problems are common to formal and informal help, and the other dynamics of change are likely to be similar, regardless of the context in which they occur.*[287]

Peer support is becoming an integral component in the management of all chronic diseases, and there is growing scientific support for such inclusion. Peer-based services, even when delivered as brief interventions, have been found effective in helping persons with severe AOD problems achieve abstinence.[288] An extensive body of research exists on the effectiveness of peer-facilitated models of change,[289] particularly within the arena of addiction recovery.[290] Such evidence includes randomized trials that included faith- and peer-based models of support.[291] Peer-based models also draw support from studies finding that recovering counselors are rated by clients as having more positive

283. White, W., & Sanders, M. (in press). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly, 26*(3).

284. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems; White, W. (2000a). Addiction as a disease: The birth of a concept. *Counselor, 1*(1), 46-51, 73; White, W. (2000b). *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. (2000c). 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.

285. Mowbray, C., Moxley, D., Jasper, C., & Howell, L. (1997). *Consumers as providers in psychiatric rehabilitation.* Columbia, MD: International Association of Psychosocial Rehabilitation Services.

286. Davidson, L., White, W., Sells, D. Schmutte, T., O'Connell, M., Bellamy, C., & Rowe, M. (submitted for publication). Enabling or engaging? The nature and role of recovery support services in addiction recovery. *American Journal of Alcohol and Drug Abuse.*

287. Moos, R.H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, *17*, 3-12.

288. Bernstein, J., Bernstein, E., Tassiopoulos, K., Hereen, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*, 49-59.

289. Durlak, J. (1979). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, *86*, 80-92; Hattie, J.A., Sharpley, C.F., & Rogers, H.J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, *95*(3), 534-541; Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry, 18*(2), 221-230; Riessman, F. (1965). The "helper" therapy principle. *Social Work*, *April*, 27-32.

290. 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; Galanter, M., Castaneda, R., & Salamon, I. (1987). Institutional self-help therapy for alcoholism: Clinical outcome. *Alcoholism: Clinical and Experimental Research*, *11*(5), 424-429; 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. (in pressc). "With a Little Help from my Friends": The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment.*

291. Stahler, G.J., Kirby, K.C., & Kerwin, M.E. (2007). A faith-based intervention for cocaine-dependent black women. *Journal of Psychoactive Drugs*, *39*(2), 183-190.

therapeutic alliance than counselors who are not in recovery[292] and studies finding that clients in programs with a higher percentage of recovering staff report greater participation in treatment and more problem improvement.[293]

P-BRSS specialists operate under numerous titles (recovery coach/mentor/guide, recovery support specialist, peer specialist, peer leader, escort). They are serving many functions, including pre-treatment engagement; assertive linkage to treatment; enhancement of treatment quality and retention; assertive linkage to communities of recovery; and post-treatment monitoring, recovery coaching, early re-intervention, and recovery community resource development. They may also be playing a broader historical role within the evolution of addiction treatment.

> *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 income 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 cooled through their maturation. P-BRSS constitute one effort to warm them back up.*[294]

There is an inevitable tension between addiction professionals who have valiantly fought to establish their credibility and turf and a new generation of peer specialists. The following principles have been suggested as a foundation for collaboration between these two groups.[295]

- P-BRSS and professionally directed addiction treatment services are complimentary rather than competitive.
- P-BRSS and treatment 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.
- Both P-BRSS specialists and treatment specialists must accurately represent and practice within the boundaries of their education, training, and experience.[296]
- The goal is to have all services—professional and peer—become person oriented, family oriented, and recovery oriented.

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292. Meir, P.S., Donnall, M.C., Barrowclough, C., McElduff, P., & Heller, R.F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction, 100*, 500-511.

293. Moos, R.H., King, M.J., Burnett, E.B., & Andrassy, J.M. (1997). Community residential program policies, services and treatment orientations influence patients' participation in treatment. *Journal of Substance Abuse, 9*, 171-187; Mavis, B.E., & Stoffelmayr, B.E. (1994). Program factors influencing client satisfaction in alcohol treatment. *Journal of Substance Abuse, 6*, 345-354.

294. White, W. (in pressc). "With a Little Help from my Friends": The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment.*

295. White, W. (in press). Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls. *Alcoholism Treatment Quarterly.*

296. 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.

## Multi-agency Collaborations

The modern history of health and human services has been marked by two trends: the movement toward specialized agencies and service professions organized around a single problem focus and a more recent trend toward service integration.[297] The first trend set up a collision between the characteristics of clients and families presenting with multiple concurrent and sequential problems and the organization of services into categorical silos. The result was a history of exclusion, extrusion, and poor outcomes for the individuals and families, as well as growing calls to create more effective, multi-disciplinary, multi-agency models of intervention. These trends have exerted a direct effect on parallel calls to extend addiction treatment from an AC to an RM model of care.

This document has already documented the problem severity and complexity of most persons entering specialized addiction treatment in the United States and will shortly summarize the problems these clients experience related to retention and post-treatment relapse. The AC Model is ill suited to treat those in greatest need of treatment, and the AC model has struggled to adapt itself to these client characteristics. Until recently, most of these efforts have involved adding service appendages (e.g., outreach or case management programs) or specialized programs that had key elements of the RM model (e.g., women's programs, child welfare initiatives, or drug court programs). These efforts have been positive and point the way to future directions for transformation of the whole treatment system. Structural elements that are likely to be incorporated into the recovery management model through these earlier initiatives include:

- multi-agency, multi-disciplinary service teams;
- integrated or aligned funding streams;
- cross training and frequent case conferences that include clients and families;
- coordinated, consistent communication of client/family expectations across all service organizations;
- an integrated assessment process;
- use of a single service plan across agencies; and
- rigorous monitoring and early re-intervention.

297. Rapp, L.A., Dulmas, C.N., Wodarski, J.S., & Feit, M.D. (1998). Integrated human service delivery system: Public welfare model. *Journal of Applied Social Sciences*, *22*(2), 151-160; White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

The integration of mental health and addiction treatment for persons with co-occurring disorders is more effective than either parallel or sequential models of treatment,[298] and it is likely we will find the same related to other co-occurring problems.

## THE SERVICE TEAM:
## POTENTIAL STRATEGIES TO ENHANCE RECOVERY OUTCOMES

- Expand delivery of primary medical services in tandem with addiction treatment.
- Assertively link each client to a primary care physician and integrate primary care physicians into treatment teams.
- Train primary care physicians to conduct regular ongoing health-focused recovery check-ups.
- Develop formal peer volunteer programs, Consumer Councils, and Alumni Associations.[299]
- Use Consumer Council and Alumni Association member teams to provide street outreach in high-dope-copping neighborhoods.[300]
- Use clients in senior status to orient and serve as guides for newly entering clients.[301]
- Develop integrated models for the treatment of co-occurring disorders.[302]

298. Mangrum, L.F., Spence, R.T., & Lopez, M. (2006). Integrated versus parallel treatment for co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment*, *30*, 79-84.

299. Leigh, G., Hodgins, D.C., Milne, R., & Gerrish, R. (1999). Volunteer assistance in the treatment of chronic alcoholism. *American Journal of Drug & Alcohol Abuse*, *25*(3), 543-559; 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.

300. 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.

301. 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.

302. Drake, E.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, *24*, 589-608.

## TABLE 5: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES: COMPOSITION OF THE SERVICE TEAM

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Primary Care | Percentage of clients who receive a physical exam<br>Percentage of clients linked to primary care during or following treatment for identified health care needs<br>Percentage of clients screened for infectious diseases<br>Percentage of clients with a primary physician at point of discharge |
| Psychiatric Care | Percentage of clients referred for psychiatric evaluation<br>Percentage of referred clients with co-occurring disorders who receive integrated addiction treatment and psychiatric services |
| Other Ancillary Services | Percentage of clients receiving the following services<br>___ Case Management Services<br>___ Transportation<br>___ Day Care<br>___ Housing Services<br>___ Financial Counseling<br>___ Educational Services<br>___ Vocational Services<br>___ Legal Counseling |

# Chapter Nine

## Service Relationship (Engagement and Retention)

### ■ SUMMARY OF KEY POINTS ■

- Pre-treatment dropout rates in addiction treatment exceed 50% of those who initially call regarding services.
- Less than half of persons admitted to addiction treatment successfully complete treatment.
- The percentage of clients administratively discharged from addiction treatment, most for confirming their diagnosis (using alcohol or other drugs while in treatment), has ranged from 10-16% in recent years—between 200,000 and 320,000 individuals per year.
- Those persons who do not complete addiction treatment, both those who drop out and those who are extruded, constitute those who are in greatest need of such treatment.
- In the transition from the AC model to the RM model, the service relationship shifts from that of professional expert to that of sustained recovery consultant.
- Promising practices in enhancing engagement and retention include the use of motivational interviewing, using most senior staff to induct new enrollees into treatment, participation incentives, altering administrative discharge policies and practices, using a choice philosophy to expand the range of client decision-making, increasing the focus on therapeutic alliance in training and supervision, and monitoring engagement indicators by service unit and by individual counselors.

In this chapter, we will examine the degree to which the current AC model of addiction treatment can engage and retain clients who present with high problem severity and compromised recovery capital. When various treatments for substance use disorders are compared, therapeutic alliance and treatment attendance outweigh differences in treatment philosophies and techniques in predicting recovery outcomes.[303] Therapeutic alliance involves multiple dimensions (empathy, rapport, safety, comfort, and hopefulness) and is not predicted by such counselor-client matching features as gender or race.[304]

303. Morgenstern, J., Blanchard, K.A., Morgan, T., Labouvie, E., & Hayaki, J. (2001). Testing the effectiveness of cognitive-behavioral treatment for substance abuse in a community setting: Within treatment and posttreatment findings. *Journal of Consulting and Clinical Psychology*, *69*(6), 1007-1017; Joe, G.W., Simpson, D.D., Dansereau, D.F., & Rowan-Szal, G.A. (2001). Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatric Services*, *52*, 1223-1229; Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of therapeutic alliance with outcomes and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438-450.

304. Sterling, R.C., Gottheil, E., Weinstein, S.P., & Serota, R. (2001). The effect of therapist/patient race- and sex-matching in individual treatment. *Addiction*, *96*(7), 1015-1022.

## Pre-treatment Drop-out Rates

Several measures reflect the initiation and maintenance of a therapeutic alliance between a client and the treatment institution and treatment professional. The first measure is the ability to rapidly engage and retain clients in the ongoing service process. This begins with the first contact with the agency, often by telephone. Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64%.[305] Over 40% of this fail-to-show group can be re-engaged by a follow-up phone call procedure,[306] but such calls are not routine in addiction treatment.

## Non-completion of Treatment

A second measure of therapeutic alliance is service retention, which can in turn be measured by such indicators as discharge status. The desired length of treatment involvement varies from individual to individual, but should ideally reach a point of successful completion of treatment components—a status consistently linked with improved long-term recovery outcomes for adults[307] but with mixed findings for adolescents.[308] Illustrated below is discharge status data for two years for those entering publicly funded addiction treatment.

| Discharge Status | 2002 | 2004 |
|---|---|---|
| Completed Treatment | 41% | 40% |
| Dropped Out of Treatment | 27% | 22% |
| Terminated by facility (administrative discharge) | 16% | 8% |
| Other or unknown (death, transfer, incarceration) | 16% | 30% |

*Sources*: SAMHSA, 2005; http://www.oas.samhysa,gov/TEDSdischarges/2K4/TEDSD2k4chp2.htm [309]

More than half of clients admitted to addiction treatment do not successfully complete their course of treatment, with most studies noting 50% dropout rates in the first month following treatment admission.[310] Even higher dropout rates are noted in certain clinical populations, e.g., 55%-77% for those admitted for cocaine or methamphetamine dependence.[311]

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305. Gottheil, E., Sterling, R.C., & Weinstein, S.P. (1997b). Pretreatment dropouts: Characteristics and outcomes. *Journal of Addictive Diseases*, *16*, 1-14.

306. Gottheil, E., Sterling, R.C., & Weinstein, S.P. (1997b). Pretreatment dropouts: Characteristics and outcomes. *Journal of Addictive Diseases*, *16*, 1-14.

307. Wallace, A.E., & Weeks, W.B. (2004). Substance abuse intensive outpatient treatment: Does program graduation matter? *Journal of Substance Abuse Treatment*, *27*, 27-30; Grella, C., Joshi, V., & Hser, Y.I. (2000). Program variation in treatment outcomes among women in residential treatment. *Evaluation Review*, *24*, 364-383; 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.

308. Winters, K.C., Stinchfield, R.D., Opland, E., Willer, C., & Latimer, W.W. (2000). The effectiveness of the Minnesota model approach in the treatment of adolescent drug abusers. *Addiction*, *95*(4), 601-612; Godley, M.D., Godley, S.H., Funk, R.R., Dennis, M.L., & Loveland, D. (2001). Discharge status as a performance indicator: Can it predict adolescent substance abuse treatment outcome? *Journal of Child & Adolescent Substance Abuse*, *11*(1), 91-109.

309. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). Treatment Episode Data Set (TEDS): 2004 Treatment Discharges. Retrieved January 30, 2008, from http://www.oas.samhsa.gov/TEDSdischrages/2k4/TEDSsk4chp2.htm

310. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *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, 2002. http://wwwdasis.samhsa.gov/teds00/TEDS_2K_Highlights.htm; http://www.dasis.samhsa.gov/teds00/TEDS_2K_Chp6.htm#Length of Stay; Stark, M. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review*, *12*, 93-116; Samantaray, P.K., Ray, R., & Chandiramani, K. (1997). Predictors of inpatient treatment completion of subjects with heroin dependence. *Indian Journal of Psychiatry*, *39*(4), 282-287.

311. Shearer, J. (2007). Psychosocial approaches to psychostimulant dependence: A systematic review. *Journal of Substance Abuse Treatment*, *32*, 41-52.

## Characteristics of Treatment Dropouts

Treatment non-completion is associated with being younger, unemployed, female, African American, self-referred, and involved with drugs other than alcohol, and not having had prior treatment.[312] Those who drop out of treatment are also characterized by lower levels of education, greater AOD problem severity, cigarette smoking, a high prevalence of psychiatric co-morbidity, greater past histories of perpetration of violence, higher-risk family living environments, lower levels of motivation for recovery, weaker therapeutic alliances, and worse long-term recovery outcomes than those who complete treatment.[313] In a study that compared residential completion rates for women by presence and severity of co-occurring psychiatric illness, women who had no co-occurring disorder completed treatment at more than twice the rate of women with a high-severity co-occurring disorder.[314] In short, **those who drop out of treatment or who are administratively discharged from treatment are those who need treatment the most.**

Also noteworthy is the role organizational factors can play in attrition. In a recent study of clients who failed to complete detoxification, those with an AMA (leaving against medical advice) discharge were more likely not to have had a single assigned physician following their care, compared to those who successfully completed.[315]

## Predictors of Engagement/Retention

Individual characteristics (e.g., psychiatric illness) can contribute to early exit from addiction treatment, but seen as a whole, those factors that contribute to early exit reflect more programmatic differences than client differences. A 2008 study of early exit from addiction treatment programs reported that clients in the worst-performing programs were 7.1 times more likely to drop out early than those in the best-performing programs. Lengthy and repeated assessment processes, multiple appointments before treatment begins, failure to give clients the treatment they requested, inadequate methadone doses, and mixing clients at differing stages of readiness for change were cited as contributors to early drop-out.[316]

The best single predictor of retention and dropout is the quality of therapeutic alliance established between the therapist and the client.[317] Retention rises in tandem with quality of therapeutic relationship.[318] Rates of client retention for therapists vary dramatically (14-81% in one well-controlled study). Such differences exist even when patient characteristics (e.g., problem severity) and therapist

312. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007). Trends in rates of treatment completion. Retrieved on February 20, 2008 from http://www.oas.samhsa.gov/TXtrends.htm; Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). Discharges who left against professional advice: 2003. *DASIS Report, 28*. Retrieved February 20, 2008 at http://www.oas.samhsa.gov/2k6/leftTX/leftTX.htm; 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. Retrieved February 20, 2008, from http://wwwdasis.samhsa.gov/teds00/6.3a.htm

313. Stark, M. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review, 12*, 93-116; Meir, P.S. Donmall, M.C., McElduff, P., Barrowclough, C., & Heller, R.F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence, 83*, 57-64; Gottheil, E., Sterling, R.C., & Weinstein, S.P. (1997b). Pretreatment dropouts: Characteristics and outcomes. *Journal of Addictive Diseases*, *16*, 1-14; Brecht, M., Greenwall, L., & Anglin, M.D. (2005). Methamphetamine treatment: Trends and predictors of retention and completion in a large state treatment system (1992-2002). *Journal of Substance Abuse Treatment, 29*(4), 295-306; Godley, M.D., Godley, S.H., Funk, R.R., Dennis, M.L., & Loveland, D. (2001). Discharge status as a performance indicator: Can it predict adolescent substance abuse treatment outcome? *Journal of Child & Adolescent Substance Abuse*, *11*(1), 91-109; Kilbourne, A.M., Salloum, I., Dausey, D., Cornelius, J.R., Conigliaro, J., Xu, X., & Pincus, H.A. (2006). Quality of care for substance use disorders in patients with serious mental illness. *Journal of Substance Abuse Treatment*, *30*, 73-77; Hser, Y.I., Maglione, M., Joshi, V., & Chao, B. (1998). *Effects of treatment program and client characteristics on client retention*. Rockville, MD: Center for Substance Abuse Treatment; De Leon, G., & Jainchill, N. (1986). Circumstance, motivation, readiness and suitability as correlates of treatment tenure. *Journal of Psychoactive Drugs*, *18*(3), 203-208; Agosti, V., Nunes, E., & Ocepeck-Welikson, K. (1996). Patient factors related to early attrition from an outpatient cocaine research clinic. *American Journal of Drug and Alcohol Abuse*, *22*(1), 29-39; , G., Melnick, G., Thomas, G., Kressel, D., & Wexler, H.K. (2000). Motivation for treatment in a prison-based therapeutic community. *American Journal of Drug and Alcohol Abuse, 26*(1), 33-46; Pelissier, B., Camp, S., & Motivans, M. (2003). Staying in treatment: How much difference is there prison to prison? *Psychology of Addictive Behaviors*, *17*(2), 134-141; Graff, F.S., Griffin, M.L. & Weiss, R.D. (2008). Predictors of dropout from group therapy among patients with bipolar and substance use disorders. *Drug and Alcohol Dependence*, *94*, 272-275.

314. Haller, D.L., & Miles, D.R. (2004). Psychopathology is associated with completion of residential treatment in drug dependent women. *Journal of Addictive Diseases*, *23*(1), 17-28.

315. Blondell, R.D., Amadasu, A., Servoss, T.J. & Smith. S.J. (2005). Differences among those who complete and fail to complete inpatient detoxification. *Journal of Addictive Diseases*, *25*(1), 94-104.

316. Stevens, A., Radcliffe, P., Sanders, M. & Hunt, N. (in press). Early exit: Estimating and explaining early exit from drug treatment. *Harm Reduction Journal*, *5*(13).

317. Barber, J.P., Luborsky, L., Gallop, R., Crits-Christoph, P., Frank, A., Weis, R., Thase, M.E., Connolly, M.B., Gladis, M., Foltz, C., & Siqueland, L. (2001). Therapeutic alliance as a predictor of outcome and retention in the National

backgrounds (e.g., education, recovery status, and years of experience) are controlled.[319]

Many people entering treatment are ambivalent about their addiction and the prospects of sustained abstinence,[320] but a strong therapeutic relationship can overcome low motivation for treatment and recovery.[321] In fact, positive therapeutic alliance is more important to long-term recovery outcomes for low-motivated clients than for highly motivated clients.[322] This finding challenges the practice of excluding or extruding people from addiction treatment due to perceived low motivation.

Engagement is also influenced by program type. Treatment completion varies by modality, e.g., 61% for short term residential, 51% for detoxification, 41% for intensive outpatient, 34% for outpatient, 33% for long-term residential, and 14% for methadone.[323] Engagement rates are higher in smaller, accredited programs characterized by staff confidence in their skills, a positive work environment, and a high level of involvement in a wider professional community.[324] Engagement and retention rates in methadone maintenance programs are higher in programs that utilize higher methadone doses and provide psychosocial support services.[325] Dropout rates in methadone treatment are influenced by clients' misconceptions about methadone and by negative attitudes toward MMT in their communities.[326]

Treatment retention for women can be enhanced by gender-specific treatment programming, but such gender-specific services are not a part of mainstream treatment.[327] Adolescents are more likely to complete treatment and to have higher post-treatment abstinence rates if they are treated in adolescent programs, rather than in programs serving all ages,[328] and when their families participate in the treatment process.[329] Similarly, Native American and African American clients treated in culture-specific programs have higher completion rates than those treated in general population programs.[330]

Recent studies have also linked family and social support outside of treatment to the quality of the therapeutic alliance within the treatment setting.[331] This finding is significant in light of the erosion of family-based programming in addiction treatment following the onset of managed care in the late 1980s.

A final point to be made regarding therapeutic alliance involves the stages at which therapeutic alliance influences outcomes. Therapeutic alliance during addiction treatment is a predictor of proximal outcomes such as retention, in-treatment abstinence and in-treatment and post-treatment gains in emotional health, but therapeutic alliance during treatment is not a consistent predictor of

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Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Journal of Consulting and Clinical Psychology*, *69*, 119-124; Meir, P.S. Donmall, M.C., McElduff, P., Barrowclough, C., & Heller, R.F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, *83*, 57-64.

318. Meir, P.S. Donmall, M.C., McElduff, P., Barrowclough, C., & Heller, R.F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, *83*, 57-64.

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321. Graham, K., Brett, P.J., & Bois, C. (1995). Treatment entry and engagement: A study of the process at assessment/referral centers. *Contemporary Drug Problems*, *22*, 61-104.

322. Ilgen, M.A., McKellar, J., Moos, R., & Finney, J.W. (2006). Therapeutic alliance and the relationship between motivation and treatment outcomes in patients with alcohol use disorder. *Journal of Substance Abuse Treatment*, *31*, 157-162.

323. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007). Trends in rates of treatment completion. Retrieved February 20, 2008 from http://www.oas.samhsa.gov/TXtrends.htm

324. Broome, K.M., Flynn, P.M., Knight, D.K., & Simpson, D. (2007). Program structure, staff perceptions, and client engagement. *Journal of Substance Abuse Treatment*, *33*, 149-158.

325. Humphreys, K., Trafton, J.A., & Oliva, E.M. (2008). Does following research-derived practice guidelines improve opiate-dependent patientsí outcomes under everyday practice conditions? Results of the Multisite Opiate Substitution Treatment study. *Journal of Substance Abuse Treatment*, *34*, 173-179; Ward, J., Mattick, R.P., & Hall, W. (1998). *Methadone Maintenance Treatment and other Opiate Replacement Therapies*. Amsterdam: Harwood Academic Publishers.

326. 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.

327. Greenfield, S.F., Trucco, E.M., McHugh, K., Lincoln, M., & Gallop, R.J. (2007). The Woman's Recovery Group Study: Stage I trial of women-focused group therapy for substance use disorders versus mixed-gender group counseling. *Drug and Alcohol Dependence*, *90*, 38-47; Claus, R.E., Orwin, R.G., Kissin, W., Krupski, A., Campbell, K., & Stark, K. (2007). Does gender-specific substance abuse treatment for women promote continuity of care? *Journal of Substance Abuse Treatment*, *32*, 27-39.

328. Harrison, P.A., & Asche, S.E. (2001). Outcomes monitoring in Minnesota: Treatment implications, practical implications. *Journal of Substance Abuse Treatment*, *21*, 173-183.

329. Stark, M. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review*, *12*, 93-116.

post-treatment substance use outcomes at treatment follow-up.[332] This suggests that the counselor relationship may play a critical role in recovery initiation, but that extra-treatment factors are more influential in achieving long-term recovery maintenance.

## Service Relationship and the Role of the Service Consumer

Studies in primary health care have found that health programs that utilize a patient self-management philosophy achieve superior outcomes and cost savings in the treatment of chronic illness. Such programs focus on enhancing the self-efficacy of the patient, improving problem solving skills, and empowering each patient as the expert on how self-management strategies can be refined to fit his or her own lifestyle. The burden of disease management shifts from the health care professional to the patient and his/her family, with the professional serving as an ongoing consultant in tandem with patient peers who have achieved self-management success.[333] Persons with alcohol and other drug problems generally prefer self-selection of their own treatment goals, but those at highest problem severity prefer therapist-set goals—perhaps reflecting their lost confidence in personal decision-making.[334]

Physicians in the primary health care setting who specialize in the treatment of chronic illnesses assume a "collaborative care" or "partnership" approach to working with their patients.[335] In this chronic-care relational model, each patient is empowered to assume responsibility for the long-term management of his or her disorder, and the physician becomes a consultant in this process.[336]

The extension of the AC Model to a RM model of care in addiction treatment will similarly alter the service relationship between addiction professionals and the individuals and families they serve. The role of "expert" who "treats" the client will give way to a teaching and consultation role (focused on self-management skill development) and a long-term recovery support alliance.[337] This role will be supported by a "choice philosophy" emphasizing the importance of clients' setting their own treatment goals and formulating their own recovery action plans.[338] This philosophy of choice and self-direction is based on studies concluding that clients who are more active in their treatment rate their treatment experience (services, primary counselor, and treatment organization) more positively, remain in treatment longer, and achieve better post-treatment recovery outcomes.[339] This choice philosophy is also congruent with calls for greater consumer voice in treatment agency policy and in broader AOD-related social policies.[340]

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The service relationship within AC and RM models of addiction treatment also has implications for service providers. The level of personal and professional satisfaction that addiction counselors experience in working with clients and families has declined in tandem with reduced duration of the service relationship over the past 30 years. This restricted period of contact means that counselors are repeatedly exposed to the worst pathologies of addiction, but are denied exposure to the blessings that individuals and families experience in long-term recovery. It is little wonder that addiction counselors become demoralized and flee the field under such circumstances. In RM models of care, counselors maintain contact with those in longer-term recovery and can draw on these rich experiences to convey hope to those entering treatment at the latest stages of addiction, many of whom cannot even envision a life in recovery.

## SERVICE RELATIONSHIP (ENGAGEMENT AND RETENTION): POTENTIAL STRATEGIES TO ENHANCE RECOVERY OUTCOMES

- Enhance client expectations of positive outcomes for treatment prior to their entry into treatment.[341]
- Involve family members in the treatment process.[342]
- Utilize motivational enhancement techniques in initial contacts with each client/family,[343] particularly with clients low in motivation.[344]
- Increase percentage of direct service staff with personal recovery backgrounds.[345]
- Conduct an initial motivational interviewing session to prepare each client for treatment.[346]
- Use the most experienced, charismatic staff to conduct induction seminars for new clients.[347]
- Minimize and clinically process staff absences.[348]
- Correct any client misperceptions about treatment and their role in it.[349]
- Use an orientation-to-treatment videotape as part of the treatment induction process.[350]
- Maintain continuity of contact over time for monitoring, support, and as-needed consultation.[351]
- Assess the quality of the therapeutic alliance throughout the treatment process.[352]
- Measure and publish a report comparing treatment programs on clients' level of satisfaction with treatment services.[353]

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- Evaluate client perception of services, counselor, and treatment organization at multiple points in the service process.[354]
- Shift from expert relational model to a partnership/alliance/consultation model.[355]
- Provide financial incentives for retention of counselors.[356]
- Provide self-management education to increase self-efficacy, problem-solving skills, and medical self-management.[357]
- Increase client choice of treatment goals, treatment methods, and recovery maintenance frameworks and strategies.[358]
- Provide decisional support at times of crisis.[359]
- Alter policies related to administrative discharge.[360]
- Provide treatment readiness training as a pre-induction process for criminal justice clients referred to addiction treatment.[361]
- Reduce staff-client ratio.[362]
- Provide case management services to eliminate obstacles to continued treatment participation.[363]
- Use contingency management procedures to elevate retention and in-treatment abstinence rates.[364]
- Formally assess early fit between the client and the right level of care, the right treatment philosophy and methods, the right provider organization, and the right counselor/team.[365]
- Utilize telephone calls, reminder notes, letters, or emails to strengthen engagement following any missed appointments.[366]
- Develop special treatment tracks for adolescents with conduct disorder or other externalizing disorders.[367]
- Provide external incentives for treatment participation, e.g., vouchers, coupons.[368]
- Provide gender-specific treatment with broad array of ancillary medical, psychiatric, and social services.[369]

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- Disseminate information to new MMT staff to counter myths and medical misinformation related to methadone and methadone maintenance.[370]
- Provide a "Methadone: Myths and Misconceptions" orientation for all clients and their family members enrolled in MMT.[371]
- Use training to reduce negative attitudes of addiction treatment staff toward sustained methadone maintenance (e.g., view that methadone should be time limited and that recovery begins only when methadone treatment is terminated).[372]
- Manage negative countertransference of service providers via clinical supervision.[373]
- Increase energy and goal-directedness of staff.[374]
- Utilize positive influence of court mandates to enhance retention of clients with antisocial personality disorder.[375]
- Fund research to evaluate strategies for managing treatment fatigue.

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## TABLE 6: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES: SERVICE RELATIONSHIP (ENGAGEMENT AND RETENTION)

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURE |
|---|---|
| Engagement | Average primary counselor-client ration |
| | Average amount of 1-to-1 time per week per client |
| | Percentage of clients who drop out in first 7 days of residential/IP care or after first OP visit |
| | Ratings of therapeutic alliance over time |
| | Percentage of clients with positive urine screens during treatment (or who surpass a set threshold of positive urine screens) |
| | Number of client/family grievances by service unit/worker |
| | Percentage of clients in detoxification linked to another level of care |
| | Percentage of clients who positively evaluate their service experience |
| Retention | Percentage of clients who receive services over a span of 90 days or more |
| | Percentage of clients who successfully complete each level of care (and analysis of discharges for those who do not) |
| | Number of administrative discharges per month and grounds for discharge; Percentage of AD as portion of total discharges |
| | Percentage of clients who participated in 80% or more of scheduled sessions (for OP Modalities) |
| Transition | Percentage of clients assertively linked to another level of care following completion of a level of care |

# Chapter Ten

## Service Dose, Scope, and Quality

### ■ SUMMARY OF KEY POINTS ■

- Length of service contact is the best single predictor of post-treatment addiction recovery status.
- Length of time in treatment has decreased through the modern evolution of addiction treatment, rendering ever briefer the service relationship within the AC model of treatment.
- The majority of clients discharged from addiction treatment in the United States receive less than the 90 days of service contact recommended by the National Institute on Drug Abuse.
- Expanding the scope of ancillary medical, psychiatric, and recovery support services in addiction treatment can elevate long-term recovery outcomes, but such service comprehensiveness is not the norm within the addiction treatment service sector.
- Progress is being made integrating evidence-based practices within mainstream addiction treatment, but treatment methods continue that are ineffective or potentially harmful.
- Promising practices related to the dose, scope, and quality of addiction treatment services include greater use of stepped care, more assertive linkage to recovery support groups and post-treatment recovery support institutions (e.g., recovery homes, recovery schools, and recovery ministries), co-location of medical/psychiatric/social services, increased emphasis on evidence-based treatments, increased monitoring of fidelity to preferred service methods via clinical supervision, and increased communication between clinicians and researchers.

### Service Dose

The concept of service dose encompasses the total quantity of treatment and recovery support services provided to an individual/family, the total span of time over which such services are delivered, and the relative volume of each service ingredient (e.g., length of an individual or group counseling session, medication dosage).

The best single predictor of post-treatment outcome across all modalities is length of time in treatment.[376] There is a dose effect of both treatment and recovery mutual aid participation, with recovery outcomes improving as dose increases.[377] The exception to this finding is that "unusually long" stays in residential and non-methadone outpatient treatment are linked to less successful outcomes—perhaps as a proxy for high problem severity and complexity.[378]

Service dose is particularly important for those clients with greater problem severity and complexity, whereas those with low-to-moderate problem severity can exhibit substantial improvement with lower doses of services.[379] The concept of "minimal retention threshold" is an important principle in elevating treatment outcomes.[380] Dose seems particularly important for more intractable patterns of drug dependence. In a five-year follow-up study of opiate addicts treated in 18 outpatient methadone clinics, those clients who had a longer period of initial treatment were more likely to be in stable recovery at follow-up.[381]

Based upon a review of treatment outcome research, the National Institute on Drug Abuse defined a threshold of approximately 90 days (for residential and outpatient drug-free treatments) as the treatment duration below which recovery outcomes began to deteriorate for most clients.[382] The median length of stay for all discharged non-methadone clients treated in the United States is far below that goal (52 days for outpatient, 42 days for intensive outpatient, 33 days for long-term residential, 21 days for short-term residential, 10 days for hospital residential, and 3 days for detoxification).[383] The effectiveness dose for methadone maintenance is at least one year of participation.[384] In 2002, the average length of time from admission to discharge in outpatient methadone maintenance was 175 days.[385]

Treatment duration in methadone and non-methadone treatment units has declined nationally in the past decade.[386] Clients with shorter lengths of stay have poorer rates of post-treatment abstinence and higher treatment readmission rates.[387] In a recent interview, Dr. Douglas Anglin, a pioneer in the study of "addiction careers," lamented the lost understanding of the importance of treatment dose.

> *It has been very disappointing in recent decades to see both in-patient and out-patient services stripped down to what I consider clearly sub-threshold levels for many chronic drug problems; currently, such programs are typically capable of producing only a short-term blip in behavior and personal recovery trajectories.*[388]

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This concern about dose even applies to those modalities that extend over more sustained periods of time. Compared to those with less time in treatment, the odds of positive outcomes at one-year follow-up are five times greater for clients who remain involved in treatment for more than a year.[389] This duration-of-involvement principle also applies to methadone maintenance treatment (MMT). The improvements associated with MMT participation often dissipate when individuals stop treatment.

The majority of persons leaving MMT quickly relapse, and up to two-thirds later return to treatment—often for repeated episodes of treatment.[390] Such outcomes are even worse for clients who only receive opiate detoxification. Detoxification clients experience high aftercare dropout rates, high readmission rates, and high death rates in the year following discharge.[391]

Treatment cycling in MMT is all too often the norm when methadone is delivered within an acute-care model. Such models are characterized by staff ambivalence or negativity toward methadone, low methadone dosages, pressure for detoxification, high dropout and administrative discharge rates, and a pervasive view that recovery does not begin until methadone detoxification is completed.

The importance of volume of each service unit can be illustrated by briefly reviewing the research on methadone dosage. There is a direct relationship between methadone dosage and the odds of continued heroin use in MMT.[392] Based on a review of the scientific literature and a survey of methadone treatment programs, Pollack and D'Aunno[393] estimate that two-thirds of MMT clients receive inadequate daily dosages of methadone—dosages below 80 mg/day. They further report that methadone doses did not change between 2000 and 2005, in spite of growing evidence that higher dosages reduce rates of opiate relapse, reduce secondary drug use, and contribute to global recovery outcomes.[394]

Dosage can also be thought of in terms of the percentage of recommended doses that are consumed. For example, in a study of naltrexone adherence in the treatment of alcohol dependence, short-term relapse rates varied from 14% to 50% depending on whether naltrexone was used regularly or less than 10% of the prescribed doses were consumed.[395] Medication adherence and adherence to other recommended self-management protocols are major problems in the treatment of all chronic disorders.[396]

The shift from an acute-care model of addiction treatment to a model of sustained recovery management seeks an adequate dose of services within each level of care and an adequate dose

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of each service ingredient within each level of care. However, RM is more than the usual lament that residential programs need longer lengths of stay and outpatient counselors need more sessions. Recovery management is focused on increasing and integrating the total dose of clinical and recovery support services across levels of care.

## Service Scope

The combinations of ingredients that spark and sustain recovery vary by problem severity. This suggests the limitations of single-service settings and the potential advantages of programs that offer multiple service components and delivery media.[397] Studies consistently reveal that providing a greater number of collateral services (e.g., medical, psychiatric, family, employment services) during addiction treatment can increase outcomes across multiple domains by as much as 25-40%.[398] The lack of integrated (concurrent, co-located) care for co-occurring substance use and psychiatric disorders has been linked to poor recovery outcomes and cost ineffectiveness,[399] and integrated models of care have been linked to improved post-treatment recovery rates,[400] yet only a little more than half of specialized addiction treatment programs provide such integrated care.[401]

Utilization of ancillary services is dramatically increased when services are provided on-site at addiction treatment facilities, compared to services accessed through referral processes,[402] but on-site service comprehensiveness is the exception rather than the rule in addiction treatment.[403] Providing a wider range of medical, psychiatric, and social services is associated with accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), but less than a third of specialized addiction treatment providers are JCAHO accredited.[404]

Within MMT programs, concerns include staff beliefs about methadone that may inadvertently or purposely encourage termination of MMT,[405] the limited availability of pharmacotherapy alternatives to methadone (e.g., buprenorphine and naltrexone), and the need for enriched drug counseling and ancillary health and social services (e.g., HIV/AIDS- and Hepatitis C-related services, linkage to employment or vocational services).[406] Such services are associated with improved MMT outcomes via reduced heroin and cocaine use.[407] There is also concern that opiate-dependent clients treated in non-MMT modalities lack evidence-based services linked to improved long-term recovery outcomes.[408]

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395. Volpicelli, J.R., Rhines, K.C., Rhines, J.S., Volpicelli, L.A., Alterman, A.I., & O'Brien, C.P. (1997). Naltrexone and alcohol dependence: Role of subject compliance. *Archives of General Psychiatry*, *54*, 737-742.

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403. 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.

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406. Ducharme, L.J., Knudsen, H.K., & Roman, P.M. (2006). Availability of integrated care for co-occurring substance abuse and psychiatric conditions. *Community Mental Health Journal*, *42*(4), 363-375.

407. Gossop, M., Stewart, D., & Marsden, J. (2006). Effectiveness of drug and alcohol counseling during methadone treatment: Content, frequency, and duration of counseling and association with substance use outcomes. *Addiction*, *101*, 404-412; Ball, J.C., & Ross, A. (1991). *The effectiveness of methadone maintenance treatment: Patients, programs, services and outcomes*. New York: Springer Verlag.

The need for linkage and integration between AOD treatment and primary care is a particularly important issue for long-term recovery. There are more than 70 medical conditions requiring hospitalization that are related to excessive AOD consumption,[409] and substance-dependent individuals often present at hospitals with one or more other chronic illnesses and without a primary care physician.[410] It is therefore surprising that little attention has been given to integrating medical care within the sustained process of addiction treatment and recovery. Studies of such integration have found that the provision of primary care during addiction treatment can be effectively achieved and reduces emergency room visits and days of inpatient hospitalization in the year following treatment.[411] And yet, as noted earlier, clients in mainstream addiction treatment will spend little time with physicians or other primary health care professionals as part of their treatment experience.

The percentage of addiction programs offering ancillary medical, psychiatric, and social services declined in the 1980s and then remained static throughout the 1990s, with two exceptions: an increase in physicals in the early 1990s and an increase in financial counseling in the late 1990s.[412]

## The Quality of Treatment and Support Services

The question of the quality of addiction treatment has been a subject of considerable focus in recent years.[413] Here we will touch on only a few issues related to quality to show how the larger arena of quality improvement fits into the movement toward a recovery management model.

Any discussion of the quality of addiction treatment quickly leads to the gap between clinical research and clinical practice within the addictions field. In 1987, Dr. Enoch Gordis, then Director of the National Institute on Alcohol Abuse and Alcoholism, offered the following as an opening salvo on this troubling dichotomy.

> *Our whole treatment system, with its innumerable therapies, armies of therapists, large and expensive programs, endless conferences, innovation and public relations activities is founded on hunch, not evidence, and not on science...Yet the history of medicine demonstrates repeatedly that unevaluated treatment, no matter how compassionately administered, is frequently useless and wasteful and sometimes dangerous or harmful. The lesson we have learned is that* ***what is plausible may be false and what is done sincerely may be useless or worse****.*[414]

408. Ducharme, L.J., Knudsen, H.K., & Roman, P.M. (2006). Availability of integrated care for co-occurring substance abuse and psychiatric conditions. *Community Mental Health Journal*, *42*(4), 363-375.

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410. DeAlba, I., Samet, J.H., & Saitz, R. (2004). Burden of medical illness in drug- and alcohol-dependent persons without primary care. *The American Journal on Addictions*, *13*(1), 33-45.

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413. Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, DC: National Academy Press.

414. Gordis, E. (1987). Accessible and affordable health care for alcoholism and related problems: Strategy for cost containment. *Journal of Studies on Alcohol, 48*(6), 579-585.

Calls for "enhanced quality of care," "evidence-based treatment," "technology transfer," and "performance measurement" have increased in the addiction treatment arena since Dr. Gordis's challenge.[415] The future of addiction treatment may well be determined by our ability to close this gap between science and practice.[416]

Progress has been made in this area, including SAMHSA's National Registry of Effective Programs and Practices, the emphasis on evidence-based training within CSAT's Addiction Technology Transfer Centers, CSAT's Treatment Improvement Protocols (TIPS), the growing use of manual-guided therapies in addiction treatment,[417] and the efforts of private groups (e.g., the National Network for the Improvement of Addiction Treatment, the Betty Ford Institute, the Washington Circle Group) to translate research into models that articulate clinical practice implications. But there are many obstacles to evaluating and applying the available evidence within different demographic and clinical populations, service settings, and service roles,[418] first of which is the lack of consensus on what constitutes "evidence" and how to interpret conflicting findings across studies.[419]

One factor contributing to this challenge is that researchers and clinicians in the field of addiction treatment live and travel in their own professional silos, with each group speaking a specialized argot and communicating through conferences and publications that rarely cross the divide.[420] Researchers charge that clinicians lack knowledge of basic addiction science and employ practices that lack empirical support or that have been proven ineffective or even harmful.[421] Clinicians contend that researchers address clinically irrelevant questions; fail to make their findings accessible; and offer implications of their studies that have no face experiential value or, even worse, are viewed by clinicians as harmful to clients, families, and communities.[422] All too often clinicians and researchers live in separate worlds, each viewing the other from a position of distance and condescension (if not contempt)—each feeling in possession of truths to which the other is blind.

We will look quite specifically at the outcomes of addiction treatment in Chapter 14, but some introductory remarks from that body of research are warranted here. Perhaps the place to begin is to acknowledge that addiction treatment is not a homogenous entity.

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416. Lamb, S., Grenlick, M.R., & McCarty, D. (Eds.). (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment.* Washington D.C.: National Academy Press.

417. Godley, S.H., White, W., Diamond, G., Passetti, L., & Titus, J. (2001). Therapist reactions to manual-guided therapies for the treatment of adolescent marijuana users. *Clinical Psychology: Science and Practice*, *8*(4), 405-417.

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419. McLellan, A.T., Chalk, M., & Bartlett, J. (2007). Outcomes, performance, and quality—What's the difference? *Journal of Substance Abuse Treatment*, *32*, 331-340.

420. Miller, W.R.. Sorensen, J.L., Selzer, J.A., & Brigham, G.S. (2006). Disseminating evidence-based practices in substance abuse treatment: A review with suggestions. *Journal of Substance Abuse Treatment*, *31*, 25-39.

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## Organizational Influences on Outcomes

Addiction treatment organizations differ considerably in their effectiveness,[423] and even a program's public reputation is not a good measure of service quality and long-term recovery outcomes.[424] Across programs, post-treatment abstinence rates vary by as much as 42%.[425] Most of these differences represent variability unique to the individual program rather than broad categorical differences (e.g., urban versus rural programs), which are often less than what one might expect.[426] One categorical difference that has been noted is that private programs are more likely than public programs to operate on a "for-profit basis," to treat a predominately alcohol-dependent client population, to utilize counselors with advanced degrees, to utilize pharmacotherapy as part of the treatment regimen, and to offer treatment for other problems (e.g., eating disorders, pathological gambling), but are less likely to provide ancillary services (e.g., transportation, child care).[427] There has been no definitive analysis, however, comparing treatment outcomes of private and public programs.

The differences in outcomes between programs seem to represent variations within rather than across particular treatment philosophies. Differences between treatments have been found to be minimal in well designed, multi-site clinical trials comparing promising evidence-based treatments aimed at dependence on alcohol,[428] cocaine[429] methamphetamine,[430] and cannabis.[431] While the outcomes of treatment-matching studies have been disappointing, there is evidence that mismatches between clients and treatment methods can compromise positive outcomes, e.g., poorer outcomes when clients with medium-to-high levels of anger were involved in therapies with higher confrontation strategies[432] and poorer outcomes in family therapy with adolescents whose parents have substance-related problems.[433]

When such mismatches can be avoided, differences in outcomes appear to be linked to two primary in-treatment factors: the differential skills of individual counselors and the effectiveness of particular program service ingredients. The findings of positive treatment effects in controlled trials without significant differential effects by level of care or theoretical orientation add credence to the potential for common factors of effectiveness[434] that are shared by major treatment modalities and that encompass both organizational factors (e.g., philosophical concordance within and between treatment organization units)[435] and helper factors (e.g. therapist traits).[436]

423. McLellan, A.T., Grissom, G.R., Brill, P., Durell, J., Metsger, 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; Miller, W., Taylor, C., & West, J. (1980). Focused versus broad-spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology*, *48*, 590-601; Valle, S. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol*, *42*, 783-790; 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; 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; Moos, R.H., Finney, J.W., & Cronkite, R.C. (1990). *Alcoholism treatment: Context, process and outcome*. New York: Oxford University Press; Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, *8*, 455-474; Magura, S., Nwakeze, P.C., Kang, S.Y., & Demsky, S. (1999). Program quality effects on patient outcomes during methadone maintenance: A study of 17 clinics. *Substance Use & Misuse*, *34*, 1299-1324.

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425. McLellan, A.T., Grissom, G.R., Brill, P., Durell, J., Metsger, 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.

426. Knudsen, H.K., Johnson, J.A., Roman, P.M., & Oser, C.B. (2003). Rural and urban similarities and differences in private substance abuse treatment centers. *Journal of Psychoactive Drugs*, *35*, 511-518.

427. Roman, P.M., Ducharme, L.J., & Knudsen, H.K. (2006). Patterns of organization and management in private and public substance abuse treatment programs. *Journal of Substance Abuse Treatment*, *31*, 235-243.

428. Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

429. Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L.S., Muenz, L., Thase, M.E., Weiss, R.D., Gastfriend, D.R., Woody, G., Barber, J.P., Butler, S.F., Daley, D., Salloum, I., Bishop, S., Najavits, L.M., Lis, J., Mercer, D., Griffin, M.L., Moras, K., & Beck, A.T. (1999). Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry*, *56*, 493-502.

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## Staff Influence on Outcomes

Individual addiction counselors also vary widely when the counseling process is evaluated on such critical variables as engagement, retention, discharge status, participation in continuing care activities, and post-treatment abstinence.[437] Differences in clinician effectiveness account for more variation in treatment outcomes than do differences in treatment philosophies and techniques or baseline characteristics of clients.[438]

In general, **long-term** recovery outcomes are not shaped by the recovery status of the counselor, although some earlier-cited studies found that addiction professionals in recovery did have better proximal recovery measures (e.g., alliance) than addiction professional not in recovery.[439] What does seem to matter in terms of recovery outcomes are key counselor traits: low level of hostility; hope, optimism, and confidence; a high degree of empathy; respect; genuineness; concreteness; minimal wish to control; and enjoyment in helping those with AOD problems.[440]

## The Role of Evidence-based Ingredients

Addiction treatment can have beneficial, neutral, or harmful effects.[441] Variability of outcome by program and counselor is influenced by the particular service ingredients they employ.

Many treatment professionals oppose the increased use of modalities that have substantial scientific support, e.g., community reinforcement approach, methadone maintenance, and other pharmacotherapies.[442] There are a growing number of pharmacological adjuncts in the treatment of addiction (most aimed at treating alcohol or opiate dependence).[443] These medications include:

- aids in detoxification, e.g., benzodiazepines (e.g., Valium), used to facilitate the safe elimination of substances from the body;
- stabilization agents such as methadone and buprenorphine that enhance metabolic stability, reduce post-detoxification cravings, and reduce relapse;
- aversive agents such as Antabuse (disulfram), which provide a chemical shield against impulses to use by eliciting toxic reactions (e.g., flushing, nausea/vomiting, increased heart rate) to even a small intake of alcohol;
- neutralizing agents (antagonists), such as naltrexone when it is used in the treatment of opiate addiction, which neuter the ability of opiates to induce euphoric effects;

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432. Karno, M.P., & Longabaugh, R. (2005). An examination of how therapist directiveness interacts with patient anger and reactance to predict alcohol use. *Journal of Studies on Alcohol, November*, 825-832; Karno, M.P., & Longabaugh, R. (2007). Does matching matter? Examining matches and mismatches between patient attributes and therapy techniques in alcoholism treatment. *Addiction*, *102*, 587-596.

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434. Hubble, M.A., Duncan, B.L., & Miller, S.D. (Eds.). *The heart and soul of change*. Washington D.C: American Psychological Association.

435. Melnick, G., Wexler, H.K., & Cleland, C.M. (2008). Client consensus on beliefs about abstinence: Effects of substance abuse treatment outcomes. *Drug and Alcohol Dependence, 93*, 30-37.

436. Najavits, L.M., Crits-Christoph, P., & Dierberger, A. (2000). Clinicians' impact on substance abuse treatment. *Substance Use & Misuse*, *35*, 2161-2190.

437. Najavits, L.M., Crits-Christoph, P., & Dierberger, A. (2000). Cliniciansí impact on substance abuse treatment. *Substance Use & Misuse*, *35*, 2161-2190.

438. Najavits, L.M., Crits-Christoph, P., & Dierberger, A. (2000). Cliniciansí impact on substance abuse treatment. *Substance Use & Misuse*, *35*, 2161-2190.

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440. Miller, W.R. (1985). Motivation for treatment: A review with special emphasis on alcoholism. *Psychological Bulletin*, *98*, 84-107; Washton, A., & Stone-Washton, N. (1990). Abstinence and relapse in cocaine addicts. *Journal of Psychoactive Drugs, 22*, 135-147; Woody, G.E., McLellan, A.T., Luborsky, L., & OiBrien, C.P. (1990). Psychotherapy and counseling for methadone-maintained opiate addicts: Results of research studies. *NIDA Research Monograph, 104*, 9-23; Najavits, L.M., Griffin, M.L., Luborsky, L, Weiss, R.D., Liese, B.L., Thompson, H., Nakayam, E., Siqueland, L, Daley, D., & Onken, L.S. (1995). Therapistsí emotional reactions to substance abusers: A new questionnaire and initial findings. *Psychotherapy*, *32*, 669-677; 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.

441. Moos, R.H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction*, *100*, 1240-1248.

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- anti-craving agents, such as naltrexone, nalmefene, and acamprosate, which are used in the treatment of alcoholism to reduce post-withdrawal cravings for alcohol and reduce the rewarding effects of alcohol if it is consumed; and
- agents such as antidepressants, mood stabilizers, and neuroleptic (anti-psychotic) medications that are used to treat co-occurring psychiatric disorders, and are also common in addiction treatment, given the increasingly high co-occurrence of depression, bi-polar disorder, anxiety disorder, and psychosis.

Access to new medications to treat addiction can be limited by combinations of public and professional attitudes and patient ambivalence about the pharmacotherapeutic treatment of addiction.[444] It should also be noted that there are at the moment of this writing (July, 2008) no viable medications for dependence on cocaine, methamphetamine, or cannabis dependence. The established effectiveness of certain medications and the future potential of new medications' innovative delivery systems (e.g., aerosols, transdermal patches, high-speed injection, implantable pumps, and very long-acting implants) in the treatment of addiction[445] will have to be balanced against the long history of iatrogenic insults (treatment-caused harm) resulting from pharmacological approaches to such treatment.[446]

There is widespread research support for family involvement and family-based therapies, but the unit of service in addiction treatment remains the individual. When available, family- and couples-based therapies are often based on approaches lacking scientific evidence of their effectiveness.[447] Widely praised treatments such as cognitive behavioral approaches have earned substantial evidence of their efficacy but have been subject to criticism for their ineffectiveness with historically disempowered groups such as the poor or homeless.[448] The failure of the research community to adapt science-based treatments to real-world applications has slowed the adoption of key evidence-based practices.[449]

Addiction treatment programs continue to utilize methods that lack evidence of their scientific effectiveness or that have been found to be potentially harmful.[450] A recent historical and scientific review of the use of confrontation techniques in addiction treatment drew the following conclusion.

> *It is time to declare a final moratorium on the use of harsh, humiliating confrontational techniques in addiction treatment. It is time to lay to rest once and for all the arrogant notion that we should or even can dismantle other human beings and then put them back together in better*

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450. Miller, W.R., Wilbourne, P.L., & Hettema, J.E. (2003). What works? A summary of alcohol treatment outcome research. In R.K. Hester, & W.R. Miller, (Eds), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed., pp. 13-63). Boston, MA: Allyn & Bacon; Miller, W.R., Zweben, J., & Johnson, W. (2005). Evidence-based treatment: Why, what, where, when, and how? *Journal of Substance Abuse Treatment*, *29*(4), 267-276; Miller, W.R.. Sorensen, J.L., Selzer, J.A., & Brigham, G.S. (2006). Disseminating evidence-based practices in substance abuse treatment: A review with suggestions. *Journal of Substance Abuse Treatment*, *31*, 25-39; White, W., & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, *8*(4), 12-30; Miller, W.R., Benefield, R.G., & Tonigan, J.S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*, *61*, 455-461.

*and wiser form. With impressive consistency, research tells us that authoritarian confrontation is highly unlikely to heal and may well do harm, particularly to the more vulnerable among those we serve. Within this context, such confrontational treatment is professionally unethical, and is doubly problematic when used with coerced populations such as court-ordered or employer-mandated populations.*

*American addiction treatment took an aberrant detour and went far afield with confronting in aggressive and even cruel ways. This created a self-fulfilling cycle whereby clients became defensive, thus reinforcing the belief that still more forceful confrontation was required. It is time to conduct a historical self-inventory of such practices, admit that these practices were ill-chosen, end their use, make amends where we can to those injured by such practices, and embrace different practices that are more effective and more respectful.*[451]

While addiction professionals espouse support for the goal of using research to improve the quality of addiction treatment, a substantial percentage of those surveyed support increased use of methods that have been found to be lacking in scientific support or found to be ineffective and potentially harmful.[452] There is, however, recent survey evidence that some of these attitudes are changing[453] compared to those revealed in earlier studies.[454]

There have been some notable successes during the past two decades. Recent studies suggest that the long-term recovery outcomes of women may be enhanced when they are treated in gender-specific treatment settings and women-focused therapy groups.[455] Gender-specific addiction treatment services grew dramatically in the 1980s and early 1990s, as did programs specifically designed for other historically disempowered groups, but such tailored treatment practices then declined between 1995 and 2005.[456]

## Spirituality and Recovery from Chronic Illness

Spirituality entails many critical dimensions, including: confidence that life has meaning, the experience of interconnectedness with others, the experience of transcendence (connection with power outside the self), and a belief in the sacredness of life.[457] The potential role of spirituality in addiction recovery and recovery from other chronic illnesses has been well documented in the scientific literature[458] but has only recently been subjected to randomized trials.[459]

451. White, W., & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, *8*(4), 12-30.

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455. Greenfield, S.F., Trucco, E.M., McHugh, K., Lincoln, M., & Gallop, R.J. (2007). The Woman's Recovery Group Study: Stage I trial of women-focused group therapy for substance use disorders versus mixed-gender group counseling. *Drug and Alcohol Dependence*, *90*, 38-47.

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461. Arnold, R.M., Avants, S.K., Margolin, A., & Marcotte, S.J. (2002). Patient attitudes concerning the inclusion of spirituality into addiction treatment. *Journal of Substance Abuse Treatment, 23*, 319-326.

Spirituality is an underutilized dimension of addiction treatment[460] in spite of the desire of most clients to have spirituality as a component of their addiction treatment experience,[461] findings that spiritual orientation/experiences can enhance recovery outcomes[462] and findings that spiritual components of treatment can be beneficial regardless of a client's degree of or lack of spiritual orientation prior to admission.[463]

Recovery Management models, because they focus on sustained recovery over the life course, place considerable emphasis on spirituality, life meaning and purpose, and quality of life.[464]

## DOSE, SCOPE, AND QUALITY OF SERVICES: POTENTIAL STRATEGIES TO ENHANCE RECOVERY OUTCOMES

- Increase the number of active ingredients in the service menu.[465]
- Educate staff on the natural history of chronic heroin addiction and the long-term value of MMT.[466]
- Provide treatment for PTSD concurrent with treatment for substance use disorders.[467]
- Provide family-focused treatment that significantly involves family members in the treatment process.[468]
- Co-locate medical and psychiatric services within primary addiction treatment settings[469] or establish effective linkages for such services.[470]
- Develop long-term care and recovery support plans for clients with multiple prior episodes of service utilization.[471]
- Provide on-site delivery of ancillary medical and psychosocial services.[472]
- Provide vocational training and assistance as a post-treatment recovery support service.[473]
- Provide assertive linkage to outpatient treatment and peer-based recovery support groups following residential treatment.[474]

462. 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), 177-86; Carroll, S. (1993). Spirituality and purpose in life in alcoholism recovery. *Journal of Studies on Alcohol, 54*, 297-301.

463. Sterling, R.C., Weinstein, S., Hill, P., Gottheil, E., Gordon, S.M., & Shorie, K. (2006). Levels of spirituality and treatment outcome: A preliminary examination. *Journal of Studies on Alcohol*, *July*, 600-606.

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## TABLE 7: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURE |
|---|---|
| Dose of Services | Percentage of clients who receive services over a span of 90 days or more<br>Percentage of MMT clients who are engaged in treatment for a minimum of one year<br>Average percentage of scheduled OP sessions attended prior to discharge<br>Percentage of detoxification clients assertively linked to another level of care<br>Percentage of inpatient and residential clients assertively linked to OP services<br>Percentage of MMT clients receiving doses below 80 mg per day |
| Scope of Services | Percentage of clients who received a physical exam<br>Percentage of clients with a primary care physician involved in their treatment or follow-up<br>Percentage of clients receiving concurrent mental health services<br>Volume of ancillary services delivered per month |
| Quality of Services | Client ratings of therapeutic alliance<br>Client/family ratings of organization, services, and primary service provider<br>Fidelity to evidence-based practice ratings by clinical supervisors |
| Services Focusing on Quality of Life | Percentage of clients who have completed a master recovery plan at discharge<br>Percentage of clients participating in alumni association events within 90 days following discharge<br>Percentage of clients agreeing to post-treatment recovery check-ups<br>Inclusion of quality-of-life measures in all treatment follow-up and long-term recovery studies |

473. Magura, S. (2003). The role of work in substance dependency treatment: A preliminary overview. *Substance Use & Misuse*, *38*(11-13), 1865-1876; Magura, S., Staines, G.L., Blankertz, L., & Madison, E.M. (2004). The effectiveness of vocational services for substance users in treatment. *Substance Use & Misuse*, *39*(13&14), 2165-2213.

474. 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.

# Chapter Eleven

## Locus of Service Delivery:

## Influence on Post-treatment Recovery Environment

### ■ SUMMARY OF KEY POINTS ■

- Most addiction treatment services are institution based; service providers have little contact with the natural environments of the individuals and families who consume their services.
- Post-treatment family and social environments play significant roles in the long-term recovery process.
- Recovery can potentially destabilize intimate and family relationships that have survived the wounds inflicted by addiction.
- Families can benefit from extended post-treatment monitoring and support.
- Clients deeply enmeshed in drug cultures face special challenges in transitioning from recovery initiation in institutional settings to recovery maintenance in their natural environments.
- Greater attention needs to be focused on the ecology of long-term recovery.
- Promising practices related to locus of service delivery and shaping the post-treatment recovery environment include assertive linkage to communities of recovery, home- and neighborhood-based services, abstinence-based social clubs, recovery support centers, development and/or use of recovery homes and recovery schools, use of indigenous healers and institutions (e.g., folk healers, recovery ministries), and use of consumer council and alumni association members to conduct street outreach and recovery coaching.

As noted earlier, the prospect of achieving stable recovery is determined in part by one's "recovery capital." The type of recovery capital needed for successful recovery changes in the transition from recovery initiation through the stages of recovery maintenance, with early recovery capital mobilized to remain abstinent and later recovery capital utilized to build a life in the community, and then to enhance personal growth, life meaning, and service to others.[475] In this chapter, we will review the shift in focus from the service environment to the natural environment of the client, as treatment

475. 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; Laudet, A.B., Becker, J., & White, W. (in press). Don't wanna go through that madness no more: Quality of life satisfaction as predictor of sustained substance use remission. *Substance Use and Misuse.*

programs extend acute-care models of intervention into more embracing models of sustained recovery management.

The principle underlying this chapter has been stated simply and eloquently as follows: "ongoing environmental factors can augment or nullify the short-term influence of an intervention".[476] There is a growing movement to understand the *ecology of addiction recovery*[477] and to take a more systems-based approach to treatment design.

> *...treatment outcomes are impacted by social institutions (including the organizational attributes of the treatment agency), role-related interactions with family and friends, and normative pressures from society and culture. The type of systems perspective helps emphasize that therapeutic process represents more than just a "clinical intervention."* [478]

## Locus of Service Delivery

Modern addiction treatment grew out of a tradition of isolating addicted persons from their natural physical and social environments. Individuals entering treatment were historically required to sever their family and social connections and enter a closed therapeutic environment (e.g., hospital, sanatorium, faith-based religious colony, residential treatment program, therapeutic community). This trend toward seeing clients in isolation from their natural environments increased as treatment evolved into a more acute intervention. It is typical of all acute-care models not to view the environment as a major concern, for four reasons: 1) acute distress is considered to have its source within, and to arise from, the individual; 2) the environment is viewed as a stage on which individual recovery decisions are made, but not as an active ingredient in the recovery process; 3) the unit of intervention is the individual; and 4) the distress caused by acute illnesses tends to disappear (at least temporarily) without any environmental intervention.

In contrast with those of acute disorders, the course and outcome of chronic disorders are heavily influenced by the physical and social environment. In the addiction context, recovery can be initiated in an artificial environment, but recovery stabilization and successful recovery maintenance can be achieved only in a natural community environment. The traditional engagement question of the acute-care model ("How do we get the client from his or her world to our world—the treatment center?") is reframed as ("How do we firmly nest the process of long-term recovery within the natural environment of the client, or, failing that, create an alternative recovery-conducive living environment within the larger community?").

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476. Moos, R.H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, *17*, 3-12.

477. White, W. (in press). "With a Little Help from my Friends": The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.

478. Simpson, D.D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment*, *27*, 99-121.

## The Problem of Transfer of Learning

The acute-care model of addiction treatment in the United States can safely detoxify and facilitate brief biopsychosocial stabilization more effectively than at any time in the country's history. The problem with this model is that it mistakes respite (brief sobriety sampling experiments within an addiction career) for sustainable recovery. Chapter 14 will provide overwhelming evidence that most people discharged from addiction treatment are fragilely balanced between recovery continuation and relapse in the days, months, and—yes—years following their discharge. The challenge is the transfer of knowledge from the institutional environment to the natural environment of each client/family and the acquisition of new recovery maintenance skills that work in that environment.

Factors in the environment may tip the scales toward recovery or re-addiction as much as individual factors do. The greater the physical, psychological, social, and cultural distance between the treatment environment and the natural environment of the client, the greater will be this transfer-of-learning challenge. This problem can be minimized through recovery management models that emphasize the inclusion of indigenous healers and institutions within the treatment process and a greater emphasis on delivering home- and neighborhood-based (e.g., health clinics, neighborhood centers) addiction treatment and recovery support services. Below we will explore the role of environment in recovery in greater depth.

## Role of Family Environment in Relapse/Recovery

Family environment exerts a great influence as a source of support or sabotage of addiction recovery.[479] Family members can play a significant role in prompting persons with AOD problems to seek treatment.[480] Family participation in treatment and family support of recovery efforts exert significant influence on long-term recovery outcomes for adults[481] and adolescents.[482]

Alcohol-dependent persons with spouses or other family members high in emotional expression (high levels of criticism, hostility, and emotional enmeshment) are at higher risk of relapse, relapse sooner, and have more drinking days in the year following treatment than clients whose spouses and family members are more encouraging and less controlling.[483] Adolescent clients entering addiction treatment whose parents have substance use disorders enter treatment with greater problem severity and greater obstacles to recovery.[484] Frequent substance use within a client's living environment can serve to sabotage recovery efforts.[485] Post-treatment recovery outcomes of adolescents are

479. White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

480. Hingson, R., Mangione, T., Meyers, A., & Scotch, N. (1982). Seeking help for drinking problems: A study in the Boston metropolitan area. *Journal of Studies on Alcohol*, *43*(3), 273-288.

481. Isaacson, E.B. (1991). Chemical addiction: Individuals and family systems. *Journal of Chemical Dependency Treatment*, *4*(1), 7-27.

482. Risberg, R.A., & Funk, R.R. (2000). Evaluating the perceived helpfulness of a Family Night program for adolescent substance abusers. *Journal of Child & Adolescent Substance Abuse, 10* (1), 51-67.

483. O'Farrell, T.J., Hooley, J., Fals-Stewart, W., & Cutter, H.S. (1998). Expressed emotion and relapse in alcoholic patients. *Journal of Consulting and Clinical Psychology, 66*, 744-752.

484. 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.

485. Catalano, R.F., Hawkins, J.D., Wells, E.A., Miller, J.L., & Brewer, D.D. (1991). Evaluation of the effectiveness of adolescent drug abuse treatment, assessment of risks for relapse, and promising approaches for relapse prevention. *International Journal of the Addictions, 25*(9A-10A), 1085-1140; Godley, M.D., Kahn, J.H., Dennis, M.L., Godley, S.H., & Funk, R.R. (2005). The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behaviors, 19*(1), 62-70.

enhanced in homes in which alcohol and other drugs are not present.[486] In spite of these findings, family-oriented services are the exception in addiction treatment.

## Family Recovery

Research on the effects of addiction recovery on the family challenges the expectation that families rapidly regain health following recovery initiation.[487] Family structure, roles, relationships, rules, and rituals are dramatically altered through the process of addiction and must be abandoned and reformed in recovery.[488] This stressful family readjustment process has been depicted as the "trauma of recovery."[489] 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.[490]

The destabilizing effects of early recovery on family life are confirmed by subsequent studies noting high rates of depression and anxiety among family members and reports that "Early recovery was much worse than the drinking".[491] Children of parents dependent upon alcohol and other drugs demonstrate varied patterns of dysfunction and resilience, with the latter increasing as an effect of parental recovery.[492] Such research studies confirm the need for family-oriented models of treatment and family-focused post-treatment monitoring, support, and early re-intervention services.

The intergenerational transmission of substance use disorders is well established in the research literature via multiple mechanisms, e.g., genetic vulnerability, prenatal alcohol/drug exposure, early age of onset of AOD use, modeling of excessive AOD use, drug culture socialization, defective parenting, physical/emotional trauma, exposure to domestic violence, abandonment, and isolation from extra-familial support.[493] What we as a field do not know from the standpoint of science is how the recovery of a grandparent, parent, sibling or other family member influences the future resistance to or resolution of AOD problems among other family members, particularly children. This question is not part of the existing addiction research agenda, and yet constitutes one of the most important concerns facing individuals in recovery.[494]

## Living Environment and Recovery

The scales of post-treatment recovery versus post-treatment relapse are mediated in part by environmental risks (e.g., substance use in the home, substance-using friends) and environmental

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486. Godley, M.D., Kahn, J.H., Dennis, M.L., Godley, S.H., & Funk, R.R. (2005). The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behaviors, 19*(1), 62-70.

487. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

488. White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

489. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

490. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

491. 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.

492. Billings, A.G., & Moos, R.H. (1983). Psychosocial processes of recovery among alcoholics and their families: Implications for clinicians and program evaluators. *Addictive Behaviors, 8*, 205-218.

493. Capone, C. & Wood, M.D. (in press). Density of familial alcoholism and its effects on alcohol use and problems in college students. *Alcoholism: Clinical and Experimental Research*; Nature Neuroscience (multiple authors). (2005). Focus on Neurobiology of Addiction [special issue]. *Nature Neuroscience, 8*(11). Retrieved July 12, 2007 from http://www.nature.com/neuro/focus/addiction/index.html; 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; Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M.A., Fenton, B., Zhang, H., O'Malley, S.S., & Rounsaville, B.H. (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, 55, 973-979; Miles, D.R., Stallings, M.C., Young, S.E., Hewitt, J.K., Crowley, T.J., & Fulker, D.W. (1998). A family history and direct interview study of familial aggregation of substance abuse: The adolescent substance abuse study. *Drug and Alcohol Dependence*, *49*, 105-114.

494. White, W.L., & Chaney, R.A. (2008). Generational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know. Posted at www.facesandvociesofrecovery.org

495. 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; 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; 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*(Suppl 1), S63-S72; 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; Bromet, E., & Moos, R. (1977). Environmental resources and the posttreatment functioning of alcoholic patients. *Journal of Health & Social Behavior*, *18*, 326-338.

protective factors (e.g., stable marital status, stable employment, availability of recovery support groups, recovery support by family and peers).[495] The AOD use of spouses/partners, parents, and siblings within one's living environment exerts an enormous influence on treatment/recovery outcomes, and sustained addiction or recovery influences the AOD use patterns of those in one's family and social environment.[496] In situations in which intimate partners are both addicted, the post-treatment recovery or re-addiction of one partner is predictive of the recovery or addiction of the other partner.[497]

Sobriety-supportive living environments, such as the Oxford Houses or collegiate recovery communities, can elevate long-term recovery outcomes.[498] There is a dose effect of recovery homes, with longer lengths of stay associated with better long-term recovery outcomes.[499] Homelessness is a factor that dictates a poor prognosis for recovery until this condition can be altered.[500]

## Social Mediation of Recovery

The risk of relapse in the year following treatment rises in relationship to the number of heavy drinkers in a person's post-treatment social network.[501] Conversely, recovery stability is enhanced by social networks that support abstinence.[502] The role of family and social supports in enhancing or hindering recovery is particularly pronounced among adolescents.[503] One of the best predictors of the course of AOD problems is the ratio of the density of AOD-using relationships to that of recovery support relationships in one's social environment.[504]

Recovery is enhanced by both general and abstinence-specific social support, but abstinence-specific support is most critical to long-term recovery.[505] The problem with general support alone is that this category of support may include people who will enable drug use and inadvertently undermine recovery prospects.[506] Interventions that focus on creating physical and social environments conducive to recovery enhance long-term recovery outcomes.[507]

Participation in recovery support groups and identification with a larger recovery community can play significant roles in successful recovery.[508] Participation in groups such as Alcoholics Anonymous is most effective for those with a higher density of drinkers in their social network, suggesting that those with natural recovery supports may have less need for sustained A.A. involvement, whereas those with few natural recovery supports may need the regular inoculating effects of A.A. participation.[509] (See Chapter Twelve for a more detailed discussion of recovery support groups).

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## Cultures of Addiction and Recovery

The journey from addiction to recovery can be a journey between two distinct and well developed cultures.[510] Many clients entering addiction treatment in the United States are enmeshed in deeply anchored roles, relationships, and daily rituals within local drug cultures. Acute treatment provides little more than a brief (hours or days) respite from contact with these cultures, the brief nature of which can trigger a return to active alcohol or drug use, during treatment or shortly after treatment contact is broken.[511]

## Community Recovery Capital

Community recovery resources, as much as individual factors, tip the balance between recovery maintenance and relapse. For example, the prospect of personal involvement in a recovery support group rises in tandem with the geographical density of recovery support groups in one's community environment.[512] The availability of broader community supports also influences addiction and recovery careers. Studies of recovering ex-offenders re-entering the community have found that relapse rates are highest during times of reduced employment opportunities.[513] Strategies designed to nurture the development of local recovery support groups and recovery support services and to facilitate lifestyle reconstruction can widen the doorway of entry into recovery and elevate long-term recovery support group participation rates.[514]

The Native American Wellbriety Movement has a vivid metaphor to describe the acute-care model of addiction treatment. These movements see such treatment as analogous to digging up a sick tree, transplanting and nurturing it back to health, and then returning it to the same soil in which it became sick. In the Native worldview, such separation of individual, family, and tribe is unthinkable. They call for the creation of a "healing forest," through which a renewed community provides a balm for the wounds of its members. In this view, the individual, family, and community must all be treated.[515]

Such a view applied to recovery management suggests the use of community development and recovery community organization strategies to supplement traditional clinical interventions. One of the goals of recovery management is to increase community recovery capital to the point where recovery becomes socially contagious. This calls for the inclusion of indigenous healers and institutions within the treatment process and a greater emphasis on delivering home- and neighborhood-

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based (e.g., health clinics, neighborhood centers) addiction treatment and recovery support services within local communities.

Future models of addiction treatment are likely to define the way family and community systems can be wounded by AOD problems and experience parallel recovery processes.[516]

> *If the prevailing paradigm is found wanting, we may see the emergence of a new perspective that emphasizes naturalistic longitudinal observation, the epidemiology and social manifestations of a disorder, community-based participatory research, and the value of interventions in improving the health of communities instead of just individuals.*[517]

## THE RECOVERY ENVIRONMENT:
## POTENTIAL STRATEGIES TO ENHANCE RECOVERY OUTCOMES

- Coach spouses and family members on how to support recovery without high emotionality and efforts to control.[518]
- Provide relapse prevention training for couples.[519]
- Encourage the development of alternative recovery support groups within the local community.[520]
- Promote or support local recovery celebration events.
- Encourage the development of recovery homes and establish close linkages between homes and primary treatment organizations.[521]
- Establish loan programs to aid the start-up of self-directed recovery homes.[522]
- Promote abstinence-based social clubs and recovery support centers.[523]
- Place special emphasis on recovery support group involvement for persons enmeshed in heavy AOD-using social networks.[524]
- Provide guided assistance in restructuring social networks.[525]
- Use community organizations and community development strategies to increase local recovery community resources.[526]
- Confront AOD promotional forces in the local community.
- Provide opportunities for client involvement in community service activities.

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**TABLE 8: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES**

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Locus of Service Delivery | Number of home visits per service unit<br>Number of service units delivered off-site in non-treatment settings<br>Number of visits per month to clients by sponsors or other community recovery support representatives |
| Family Environment | Percentage of clients with family members involved in treatment process<br>Percentage of families assertively linked to family support groups<br>Percentage of families involved in post-treatment continuing care activities |
| Community Environment | Number of local recovery mutual aid societies<br>Number of local recovery support meetings per week<br>Number of local recovery homes<br>Total local recovery home capacity |

# Chapter Twelve

## Assertive Linkage to Communities of Recovery

### ■ SUMMARY OF KEY POINTS ■

- Participation in recovery mutual aid groups can elevate long-term recovery outcomes for diverse populations.
- The effects of recovery mutual aid involvement reflect multiple mechanisms of change and vary in terms of the number of meetings in early recovery, duration of participation, and intensity of participation.
- Combining addiction treatment and recovery mutual aid for persons with severe substance use disorders is more effective than either used alone.
- The positive effects of recovery mutual aid groups are compromised by weak linkage and a progressive attrition in participation over time.
- Half of all clients completing treatment do not participate in recovery support groups after discharge, and of those who do, 40-60% discontinue participation within a year of treatment discharge.
- Assertive linkage to a recovery support group is more effective than passive referral (verbal encouragement to attend), but the linkage process in most treatment programs is of the passive variety.
- Participation in other recovery community institutions (e.g., recovery homes, recovery schools, recovery industries, recovery support centers, recovery ministries/churches) may enhance long-term recovery, but evaluation of this potential is at an early stage.
- Promising practices related to linkage to communities of recovery include enhanced institutional linkages between treatment institutions and communities of recovery; use of assertive linkage procedures; orientation and linkage to Internet-based recovery support groups; and expansion of treatment philosophies to embrace diverse religious, spiritual, and secular pathways of recovery.

*"The benefits to be realized from developing strong social networks in support of drug-free functioning appear to provide the potential for maintaining and extending the gains from treatment."*

*— Conclusion of a five-year follow-up study of treated opiate addicts*[527]

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## Limited but Expanding Scope of Research

American communities of recovery have existed for more than 250 years and are currently growing in size, philosophical diversification (religious, spiritual, secular, abstinence-based, moderation-based), membership characteristics (age, gender, ethnicity, primary drug choice), and meeting formats (face-to-face meetings, meetings for special populations, and online meetings/resources).[528] (See http://www.facesandvoicesofrecovery.org/resources/support_home.php for a regularly updated guide to addiction recovery support groups in the United States.)

Most of what we know from the standpoint of science about recovery mutual aid groups is based on studies of Twelve Step support groups, Alcoholics Anonymous and to a lesser extent Narcotics Anonymous.[529] Early AA studies drew criticism in terms of the methods in which they were conducted,[530] but the number and methodological rigor of studies of AA have increased dramatically. Keith Humphreys summarizes:

> *Strong views about AA one way or the other will always survive, no matter what evidence accumulates, but the studies of the past 15 years have established beyond any reasonable doubt that high-quality AA trials are possible, and that such studies usually reinforce rather than undermine the excellent reputation the fellowship enjoys around the world.*[531]

Caution is indicated in applying research findings from studies of AA to other groups or to persons in recovery who do not participate in recovery support groups. AA members are a select subset of the total pool of persons with AOD problems,[532] and even studies of AA are based primarily on AA members in their early years of recovery who completed professional treatment.[533]

Few studies have been conducted of other recovery support groups or of Twelve Step members in long-term recovery.[534] The preliminary reports in the scientific and professional literature on groups such as Women for Sobriety, Rational Recovery,[535] Secular Organization for Sobriety,[536] and LifeRing Secular Recovery[537] are descriptive rather than controlled outcome studies. Given these limitations, we will proceed cautiously in summarizing what is known about peer-based recovery support groups. The extent to which findings about AA can be extended to other groups is at this time unknown.

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## Summary of Effects across Diverse Populations

Research on Alcoholics Anonymous and other recovery mutual aid groups confirms their ability to enhance long-term recovery outcomes for a broad spectrum of individuals.[538] Participation in groups such as AA also reduces alcohol-related mortality rates,[539] particularly that of alcoholism-related suicide.[540]

While criticisms of AA include references to its foundational experience with White, middle-aged men in late stages of alcoholism, recent studies have confirmed its potential effectiveness with:[541]

- women,[542]
- people of color,[543]
- young people,[544]
- people with co-occurring psychiatric disorders (including those on medication),[545]
- people without religious or spiritual orientation,[546] and
- people who use drugs other than alcohol.[547]

Women participate more and benefit more from recovery support groups following treatment than do men.[548] Similarly, African Americans are more likely to participate in AA following treatment than Caucasians.[549] There is growing evidence that drug choice is not a clear predictor of affiliation with a particular mutual aid group. In NIDA's Collaborative Cocaine Treatment Study, 83.9% of those who regularly attended support meetings attended Alcoholics Anonymous; only 24.6% had ever attended a meeting of Cocaine Anonymous.[550]

Recovery support groups (particularly AA and NA) have the advantage of being geographically accessible to most individuals, and they are available without cost (other than token contributions) and without a potentially stigma-laden medical diagnosis or life-disrupting treatment protocol.[551]

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## Dose Effects

The positive effects of peer-based recovery support groups rise in tandem with dose (the number of meetings attended).[552] Clients who attend a greater number of recovery support meetings during treatment go on to participate in a greater number of such meetings after treatment.[553] This positive dose and timing principle of mutual aid participation applies primarily to early stages of recovery, as research has documented a later style of recovery in which AA members decrease or stop meeting participation but continue their sobriety and other recovery-related activities.[554] Good recovery outcomes are also reported for at least some "non-attending participators" in early recovery (individuals who do not attend meetings but participate in other recovery-supportive activities).[555]

## Intensity Effects

In general, recovery rates improve and alcohol and drug problem severity declines as involvement with recovery support groups and intensity of participation increase (e.g., applying concepts to daily problem solving, reading recovery literature, sober socializing, service work).[556]

## Duration Effect

There is also a duration effect of AA participation: those who continue to participate in AA after the first year of involvement have better long-term recovery rates than those who did not participate in AA or those who or reduce or stop participation after year-one involvement.[557]

## Combining Treatment and Recovery Support Group Participation

Combining addiction treatment and recovery mutual aid groups is more predictive of long-term recovery than either activity alone, suggesting an additive or synergistic effect of combining these two recovery support activities.[558] Clients who attend mutual aid groups do better following treatment than clients who do not attend such groups, regardless of the type of treatment they originally received.[559] Those who participate in both treatment and AA are less likely to drop out of AA than those who participate only in AA.[560]

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Mutual aid by itself is not an effective substitute for treatment for populations characterized by high problem severity/complexity.[561] Post-treatment participation in Twelve Step groups may be more important than continued outpatient counseling in sustaining recovery,[562] and such participation has the added benefit of reducing continuing care costs[563] and post-treatment health care costs.[564] Linking clients from treatment to indigenous recovery support groups and recovery community institutions is even more important in light of the diminished access to treatment and diminished dose of treatment produced by the recent fiscal austerity and aggressive gatekeeping of managed behavioral health care.[565]

### Timing of Linkage

Clients who attend recovery support meetings during treatment, are exposed to Twelve Step literature, and are expected to build Twelve Step-related friendships and a sponsorship relationship during treatment are more likely to attend Twelve Step meetings after treatment than those who are simply referred to support meetings at the end of treatment.[566] Again, patterns of meeting attendance established during treatment tend to be sustained after treatment.[567]

### Variability of Response

Patterns of response to mutual aid exposure include the patterns of those who fully respond, those who partially respond, and those who do not respond at all.[568] In a study of clients linked to AA as part of their treatment experience, the proportion of responses to AA included 31% optimal response, 42.7% partial response, and 22.3% non-response, with the non-responders having the worst post-treatment recovery outcomes.[569] The documented variability of response and the growing recognition of multiple pathways of long-term recovery underscore recommendations for addiction treatment programs to expose their clients to a wide spectrum of secular, spiritual, and religious frameworks of long-term recovery support.[570]

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## Mechanisms of Change

Participation in recovery mutual aid groups exerts a positive influence on recovery outcomes through multiple mechanisms of change. Some of the most potent of such mechanisms identified in the research literature include the following:

- self-appraisal of harm and commitment to abstinence,[571]
- ongoing self-monitoring,[572]
- sustained remotivation for abstinence,[573]
- spirituality,[574]
- enhanced coping skills,[575]
- increased self-efficacy,[576]
- social support that offsets the influence of pro-drinking social networks,[577]
- 24-hour availability,[578]
- helping other alcoholics,[579]
- recognition of high-risk situations and stressors,[580]
- role modeling and experience-based advice on how to stay sober,[581] and
- participation in rewarding activities.[582]

Sponsoring others appears to be a particularly potent ingredient, with some long-term post-treatment follow-up studies noting over 90% remission rates in persons who sponsored others throughout the follow-up period.[583]

## Other Recovery Community Involvement

Affiliation with recovery support groups and other recovery community institutions (e.g., recovery homes, recovery schools, recovery industries, recovery support centers) may work by helping individuals transition from a dependency on drugs to a "prodependency" on people.[584]

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## Problems of Weak Linkage and Attrition

The positive findings of AA and other recovery mutual aid involvement are offset by weak relationships between treatment institutions and local mutual aid groups,[585] passive rather than assertive linkage to such groups by addiction professionals,[586] and high (40-70%) progressive dropout rates from such groups in the first year.[587]

As many as 50% of clients who complete primary treatment for a substance use disorder do not attend a single recovery support meeting following discharge from treatment,[588] and 40-60 % of clients who begin participation in Twelve Step groups discontinue participation in the 9-12 months following treatment discharge.[589] The post-treatment outcomes of individuals who stop attending support meetings, or who only attend them sporadically, descend to the levels of outcome of those who report never regularly attending.[590]

> *Given that more than 80% of individuals who obtained help eventually participated in AA, but that about half of them dropped out, interventions should focus on enhancing continuation in AA and on identifying other mutual help groups that may provide similar benefit.*[591]

Problems of linkage and engagement are particularly pronounced for young people.[592] Studies of post-treatment adolescent participation in Twelve Step groups report similar attrition problems.[593] Adults leaving addiction treatment are twice as likely to attend Twelve Step meetings in the first three months than are adolescents discharged from addiction treatment.[594] Peer-based recovery support services provide a connecting bridge between professional treatment and indigenous recovery communities.

Assertive linkage to communities of recovery early in the treatment process can increase affiliation and participation rates for adults[595] and adolescents[596] following treatment, but such assertive procedures do not constitute a mainstream treatment practice.

Linking clients to particular recovery support groups and meetings has been recommended[597] and is indicated by studies finding that adolescents who attend recovery support groups with higher proportions of young people in attendance have higher meeting attendance rates and better long-term recovery outcomes than adolescents attending groups with primarily adult members.[598] Clients also differ in their degree of religiosity and spiritual orientation and can benefit from being matched with programs that are congruent with their degree of, or absence of, such orientation.[599]

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## Role of Clinician Attitudes

Clinician attitudes play a critical role in determining whether clients in treatment initiate participation in recovery support groups.[600] Counselors may, however, overestimate their understanding of mechanisms of change involved in Twelve Step recovery because of the ubiquitous presence of references to Twelve Step groups and Twelve Step slogans.[601] Given their varied preparatory pathways and high turnover rates, addiction counselors may lack in-depth knowledge of Twelve Step programs and even a general understanding of alternative recovery support groups and recovery support institutions.[602]

### LINKAGE TO COMMUNITIES OF RECOVERY: POTENTIAL STRATEGIES TO ENHANCE RECOVERY OUTCOMES

- Emphasize the critical nature of mutual aid participation for persons with heavy alcohol/drug-using social networks.[603]
- Demonstrate "informational parity" by distributing information on the full range of recovery mutual aid alternatives.[604]
- Orient clients to the varieties of support groups, inform them of research findings on their role in recovery, and educate them on what to expect in such meetings.[605]
- Engage clients in discussions of responses to various meeting formats, application of program principles to current circumstances, status of sponsorship relationships, and fellowship-related service and social activities.[606]
- Focus on youth and adults with the most severe AOD problems for intensified linkage, monitoring, and support related to their mutual aid involvement.[607]
- Use "systematic encouragement" (call by the client to recovery support group in the presence of the counselor, mutual introduction between the client and group member over the phone to arrange transport to the first meeting, with the same group member calling before the meeting to encourage attendance) rather than passive referral (verbal encouragement to attend and provision of a list of meetings).[608]

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- Encourage sampling of recovery support groups and meeting formats.[609]
- Maintain a list of local recovery support group members willing to transport and guide a client into his or her first meeting experience.[610]
- Assertively linking clients to recovery support groups during treatment, rather than at the end of or following treatment.[611]
- Matching clients to groups based on gender, age, attitude toward spirituality, smoking status, and drug choice.[612]
- Resolve any obstacles to ongoing participation, e.g., transportation, child care.[613]
- Host on-site recovery support meetings at treatment facilities.[614]
- Facilitate involvement in activities beyond meeting attendance, e.g., reading literature, getting a sponsor, initiating sober friendships, participating in social events such as dances and parties, service work.[615]
- Improve supportiveness and goal-directedness of organizational work environment.[616]

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609. 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; Tonigan, J.S., Miller, W.R., & Schermer, C. (2002). Atheists, agnostics and Alcoholics Anonymous. *Journal of Studies on Alcohol, 63*, 534-541.

## TABLE 9: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES

| PERFORMANCE AREA | SAMPLE RECOVERY-LINKED PERFORMANCE MEASURES |
|---|---|
| Support Group Availability | Number of local recovery mutual aid societies<br>Number of local recovery support meetings per week<br>Number of recovery volunteers |
| Staff Knowledge of Recovery Support Groups | Percentage of direct service staff who have attended a local recovery support meeting in past 90 days<br>Documentation of staff training on alternative recovery pathways<br>Review the clinical chart of each client to verify use of philosophy of choice |
| Institutional Linkages to Communities of Recovery | Number of meetings between local recovery mutual aid group service committees in past quarter<br>Number of volunteers from local recovery support groups who have participated in in-treatment client education in the past month |
| Effectiveness of Linkage Procedures | Percentage of clients who report recovery support group participation 3 months, 6 months, and 12 months following treatment<br>Number of clients linked to alternative meetings or support societies after exposure to their initial choice |

610. Johnson, N.P., & Chappel, J.N. (1994). Using AA and other 12-step programs more effectively. *Journal of Substance Abuse Treatment*, *11*, 137-142.

611. 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; 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.

612. Forman, R.F. (2002). One AA meeting doesn't fit all: 6 keys to prescribing 12-step programs. *Psychiatry Online*, *1*(10), 1-6.

613. Johnson, N.P., & Chappel, J.N. (1994). Using AA and other 12-step programs more effectively. *Journal of Substance Abuse Treatment*, *11*, 137-142.

614. 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.

615. 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; Weiss, R.D., Griffin, M.L., Gallop, R.G., Najavits, L.M., Frank, A., Crits-Christoph, P., Thase, M.E., Blaine, J., Gastfriend, D.R., Daley, D., & Luborsky, L. (2005). The effect of 12-step self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence, 77*, 177-14.

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# Chapter Thirteen

## Post-treatment Monitoring, Support, and Early Re-intervention

### ■ SUMMARY OF KEY POINTS ■

- Post-treatment monitoring and support can significantly elevate long-term recovery outcomes.
- Only a small percentage (20-36%) of adolescents and adults completing addiction treatment receive post-treatment continuing care.
- RM models of continuing care are distinguished from AC models by several critical factors: Post-treatment monitoring and support is provided to all clients, not just those discharged; responsibility for continued contact lies with the service staff rather than the client; saturated support is provided in the first 90 days following discharge from treatment; and "recovery check-ups" are provided for an extended period of time (up to five years).
- The timing and duration of post-treatment support exert a greater influence on long-term recovery outcomes than the total number of support contacts or the length of each support contact.
- The telephone and the Internet constitute two underutilized media for post-treatment monitoring, support, and early re-intervention.
- Promising practices related to post-treatment monitoring and support include enhancements aimed at participation (behavioral contracts, prompts, escorts, financial incentives); removing barriers to participation; extending time-span of support via recovery check-ups, telephone- and Internet-based systems of continuing care; and expanding the range of environments in which continuing care occurs, e.g., home- and work-based follow-up.

The most dramatic difference between acute-care and recovery management models of addiction treatment is the span of time over which the service relationship is expected to extend. In the AC model, the span of involvement is expected to be short and is lengthened only by default, via the repeated relapse and readmission of clients. Treatment providers participate in the illusion of recovery stability by "graduating" clients with prolonged, severe substance use and related problems following short periods of treatment and sobriety. Yet two pervasive themes in long-term follow-up studies are that **treatment effects diminish over time** and that **relapse rates are high**.[617] This raises the

617. McKay, J.R., & Weiss, R.V. (2001). A review of temporal effects and outcome predictors in substance abuse treatment studies with long-term follow-ups: Preliminary results and methodological issues. *Evaluation Review, 25*, 113-161; 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.

question of how long addiction professionals should remain involved in the lives of their clients. The extended length of involvement advocated within the recovery management model is based on the following principle:

> *Health care professionals should remain involved and available to those they serve until long-term recovery of the condition being treated can be self-managed by the patient, family and extended support network.*

For conditions such as minor trauma or mild infection, this period of involvement can and should be relatively brief, but what about addiction? As the next chapter will document, most clients are fragilely balanced between recovery and re-addiction in the weeks, months, and early years following their discharge from addiction treatment.[618] This fragility is particularly marked for adolescents and young persons aged 18-24 seeking recovery.[619] In studies of the stability of substance use status over time, 20-40% of treated clients continue to alternate between periods of abstinence and periods of use.[620]

## Timing of Recovery Stability

The brief period of professional contact that characterizes most addiction treatment conflicts with research findings on recovery stability. Stability of alcoholism recovery—the point at which the risk of future lifetime relapse following recovery initiation drops below 15%—is not reached until four to five years of sustained remission.[621] Relapse is rare among individuals previously dependent upon alcohol who achieve seven years of continuous abstinence.[622] Stability of recovery from other drug addictions (e.g., heroin addiction) may require even longer periods of time.[623]

The core principle upon which service designs should be based is that recovery becomes more solidified and sustainable and the risk of relapse declines with the passage of time in recovery.[624] Short periods of abstinence constitute natural respites in long-term addiction careers and are best understood as processes of brief dormancy rather than sustainable recovery.[625] *The available data suggest a period of post-stabilization monitoring; stage-appropriate recovery education; active recovery coaching; and, when needed, early re-intervention for a period of at least five years.* Interestingly, this is approximately the same time period often targeted for professional monitoring of other chronic, relapse-prone conditions, e.g., cancer.

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618. 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*(Suppl 1), S63-S72.

619. 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.

620. McKay, J.R., & Weiss, R.V. (2001). A review of temporal effects and outcome predictors in substance abuse treatment studies with long-term follow-ups: Preliminary results and methodological issues. *Evaluation Review*, *25*, 113-161.

621. 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.

622. Vaillant, G.E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98,* 1043-1051.

623. Simpson, D.D., & Marsh, K.L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims & C. Luekefeld, *Relapse and recovery in drug abuse* (NIDA Monograph 72). Rockville, MD: National Institute on Drug Abuse; Hser, Y.I., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508.

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625. 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, Winter*, 107-122.

626. 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; Gunter, T.D., Black, D.W., Zwick, J., & Arndt, S. (2004). Drug and alcohol treatment services effective for methamphetamine treatment. *Annals of Clinical Psychiatry, 18*, 195-200; Pettinati, H.M., Sugerman, A.A., & Maurer, H.S. (1982). Four year MMPI changes in abstinence and drinking alcoholics. *Alcoholism: Clinical and Experimental Research*, *6*(4), 487-494.

This particular finding suggests, not longer episodes of primary treatment, but an extended period of check-ups and support. Even for the highest-functioning and most stable clients, this would include an annual recovery check-up.

## Post-treatment Emotional Support and Mental Health Service Needs

There may be specific emotional support and mental health service needs after treatment that were not present during initial treatment. Post-treatment mental health problems actually increase during years one to three and then decrease thereafter.[626] The delivery of concurrent or post-treatment mental health care enhances addiction treatment outcomes.[627] This suggests the need for sustained post-treatment monitoring of mental health service needs-monitoring that is not currently a mainstream practice in addiction treatment.

## Current Status of Post-treatment Continuing Care

Continuing care following discharge from a level of primary treatment can enhance long-term recovery outcomes,[628] but only one in five adults in the United States receives such care,[629] and only 36% of adolescents receive any continuing care following discharge from residential or outpatient treatment.[630] The aspirational ideal of the treatment system is stepped care from higher to lower intensity of service contact through an integrated continuum of care and support,[631] but this goal is achieved for only a minority of clients.[632] Such achievement varies by modality and clinical population. For example, compared to women completing mixed-gender treatment, women who complete gender-specific treatment programs have twice the rate of linkage to continuing care services.[633]

Weak linkages to continuing care are also prevalent among institutional systems of care, e.g., transitions of prisoners with addiction histories from prison to the community with no transitional treatment or recovery support services.[634] Studies on the transition from in-prison treatment programs to the community note that relapse often occurs quickly upon re-entry, and that those who have transition treatment have better recovery outcomes than those who receive only in-prison treatment and then return to the community.[635]

Obstacles to continuing care in the mainstream treatment system include "treatment burnout" (lack of motivation for continued services), geographical inaccessibility of continuing care groups, lack of transportation or child care, and resumption of AOD use.[636]

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627. Moos, R.H., Finney, J.W., Federman, E.B., & Suchinsky, R. (2000). Specialty mental health care improves patientsí 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.

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629. 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.

630. 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.

631. Sobell, L.C., & Sobell, M.B. (2000). Stepped care as a heuristic approach to the treatment of alcohol problems. *Journal of Consulting and Clinical Psychology*, *68*, 573-579.

632. 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.

633. Claus, R.E., Orwin, R.G., Kissin, W., Krupski, A., Campbell, K., & Stark, K. (2007). Does gender-specific substance abuse treatment for women promote continuity of care? *Journal of Substance Abuse Treatment*, *32*, 27-39; Stevens, S.J., & Patton, T. (1998). Residential treatment for drug addicted women and their children: Effective treatment strategies. *Drugs & Society*, *13*, 235-249.

634. Hiller, M.L., Knight, K., & Simpson, D.D. (1999). Prison-based substance abuse treatment, residential aftercare and recidivism. *Addiction*, *94*(4), 833-842.

635. Pelissier, B., Jones, N., & Cadigan, T. (2007). Drug treatment aftercare in the criminal justice system: A systematic review. *Journal of Substance Abuse Treatment*, *32*, 311-320.

636. 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; Schnitt, S.K., Phibbs, C.S., & Piette, J.D. (2003). The influence of distance on utilization of outpatient mental health aftercare following inpatient substance abuse treatment. *Addictive Behaviors*, *28*, 1183-1192.

## Evidence of Effectiveness of Sustained Recovery Monitoring and Support

There is a growing body of scientific evidence suggesting that post-treatment monitoring (recovery check-ups) and support can elevate recovery outcomes for adults[637] and adolescents.[638] Even follow-up interviews for research purposes may have hidden therapeutic effects that positively influence recovery outcomes.[639]

The effectiveness of monitoring and re-intervention seems to span all treatment modalities. A recent study of the use of outreach case management to re-engage relapsed clients following discharge from methadone maintenance showed that this intervention successfully re-engaged 29% of those who had relapsed following discharge.[640] This is a very important finding, given the treatment-related reductions in mortality associated with methadone maintenance and the post-discharge increases in morbidity and mortality associated with terminating methadone maintenance.[641]

## Assertive Approaches to Continuing Care

More sustained and assertive styles of monitoring and support following completion of inpatient or outpatient treatment mark a transition in thinking from *aftercare* (or *follow-up*) to *continuing care*[642]—from treatment *intensity* (short-term/high intensity) to treatment *extensity* (long-term/low intensity).[643] Assertive approaches to continuing care constitute one of the hallmarks of RM models of care and share several key characteristics. Such assertive approaches:

- encompass all admitted clients/families, not just those who successfully "graduate";
- place primary responsibility for post-treatment contact on the treatment institution, not the client;
- involve both scheduled and unscheduled contact;
- 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 (increase and decrease) the duration and intensity of check-ups and support based on each client's degree of problem severity and the depth of his or her recovery capital;
- utilize assertive linkage rather than passive referral to communities of recovery;

637. 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. 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; Dennis. M.L., Scott, C.K., & Funk, R. (2003). An experimental evaluation of recovery management check-ups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352; 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.

638. 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.

639. Gallen, M. (1974). Toward an understanding of follow-up research with alcoholics. *Psychological Reports, 34*, 877-878; Sobell, L.C., & Sobell, M.B. (1981). Frequent follow-up as data gathering and continued care with alcoholics. *International Journal of the Addictions, 16*, 1077-1086; Clifford, P.R., Maisto, S.A., Franzke, L.H., Longabaugh, R., & Beattie, M.C. (2000). Alcohol treatment research follow-up interviews and drinking behaviors. *Journal of Studies on Alcohol, 61*(5), 736-743.

640. 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; See also, Goldstein, M.F., Deren, S., Kang, S-Y, Des Jarlais, D.C., & Magura, S. (2002). Evaluation of an alternative program for MMTP dropouts: Impact of treatment re-entry. *Drug and Alcohol Dependence*, *70*, 193-200.

641. 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.

642. White, W., & Godley, M. (2003). The history and future of "aftercare." *Counselor, 4*(1), 19-21.

643. 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; Humphreys, K., & Tucker, J.A. (2002). Toward more responsive and effective interventions for alcohol-related problems. *Addiction*, *97*, 126-132.

- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support, and mailed and emailed communications;
- emphasize support contacts with clients in their natural environments;
- may be delivered 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.[644]

Longitudinal research has yielded technologies for engaging and sustaining contact with clients for years following their discharge from addiction treatment.[645] These technologies might be adapted for use in the development of systems for prolonged post-treatment monitoring and support and can be delivered by paid professional staff or by paid or volunteer peers in recovery.[646]

While the question of the ideal duration of continuing care remains unanswered, preliminary studies have established the principle that the duration of continuing care is more important to long-term recovery outcomes than the number of support contacts or the length of each contact that occurs over that period.[647] If duration of contact were guided by the earlier-reviewed recovery stability data, then an ideal duration of continuing care contact would be a minimum of four to five years following primary treatment. The duration of contact (more extended years of contact) and the timing of contact (more intense during the first 90 days) seem to be more important influences on long-term recovery outcomes than the total number of such contacts or the length of each contact.[648]

## Media for Delivery of Post-treatment Monitoring and Support[649]

Traditional continuing care service following addiction treatment has involved step-down care (e.g., scheduled outpatient appointments following inpatient or residential treatment, weekly aftercare groups available to all clients who have successfully completed treatment). According to a recent review,[650] two media—the telephone and the computer—are likely to play an increasingly important role as delivery mechanisms for post-treatment recovery support services.

Early studies of telephone-based post-treatment monitoring and support revealed that telephone-based contact was as potent in supporting continued recovery as participation in traditional aftercare groups.[651] The use of telephone-based continuing care gained greater credence after

644. White, W., & Kurtz, E. (2006b). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and Recovery Coaches*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center.

645. 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.

646. Gardner, S.E. (1979). The use of volunteers in drug abuse aftercare. In B.S. Brown (Ed.), *Addicts and aftercare: Community integration of the former drug user* (pp. 167-182). Beverly Hills: SAGE Publications.

647. Ritsher, J.B., McKellor, 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*(6), 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), 1300-1311.

648. 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.

649. Abstrated from Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

650. Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

651. Fitzgerald, M.A., & Mulford, H.A. (1985). An experimental test of telephone aftercare contacts with alcoholics. *Journal of Studies on Alcohol*, *46*, 418-424; Foote, A., & Erfurt, J.C. (1991). Effects of EAP follow-up on prevention of relapse among substance abuse clients. *Journal of Studies on Alcohol*, *52*, 241-248.

its utility in the treatment of nicotine addiction was confirmed both in the primary care setting (via reductions in clinic visits, hospitalizations, and fewer total hospital days)[652] and as a form of post-treatment support.[653]

One of the best-designed studies of the utility of telephone-based continuing care[654] randomly assigned alcohol- and/or cocaine-dependent participants of an intensive outpatient treatment program to one of three conditions: telephone-based continuing care, a face-to-face (F-2-F) relapse prevention group, or F-2-F Twelve Step group counseling. Participants who had been dependent on cocaine or both cocaine and alcohol did as well in telephone-based continuing care as in F-2-F groups, but those who were dependent only on alcohol actually did better in the telephone-based intervention. In follow-up reports on the same study,[655] the effects of telephone-based support did not deteriorate more rapidly than those of the F-2-F interventions. However, participants who did not achieve significant progress in intensive outpatient treatment had better long-term outcomes in F-2-F sessions than in telephone-based support.

Brief (15-minute) but sustained telephone monitoring following primary treatment has been shown in other studies to increase abstinence rates, reduce heavy drinking (by as much as 50%), postpone and shorten relapse episodes, reduce emergency room visits, and reduce the need for further primary treatment.[656] Telephone-based outreach programs have been effectively utilized to counsel and re-engage discharged methadone patients who had returned to illicit opiate use.[657] Telephone-based extended case monitoring has been demonstrated to be an effective tool with diverse populations, including adolescents,[658] American Indians, and individuals living in remote geographical areas.

An early model of extended case monitoring used a protocol that included an initial 30-minute interview with a case manager as the client neared discharge, monthly calls for three months, calls every six weeks from two contacts, and calls every two months for another nine months (resulting in 15 contacts over two years). If a client relapsed, the protocol began anew. Where available, a significant other of each client was also contacted by the case monitor on the same schedule.[659]

Typical of the new generation of telephone-based services is the Focused Continuing Care (FCC) program at the Betty Ford Center. The FCC provides telephone-based monitoring and support of patients discharged from the Center, with a focus on linking graduates to Twelve Step meetings. Calls begin a week after discharge and are sustained monthly. At one year, 88% of those being

652. Wasson, J., Guadette, C., Whaley, F., Sauvigne, A., Barbibeau, P., & Welch, H.G. (1992). Telephone care as a substitute for routine clinic follow-up. *Journal of the American Medical Association*, *267*(13), 1788-1793.

653. Rabius, V., McAlister, A.L., Geiger, A., Huang, P., & Todd, R. (2004). Telephone counseling increases cessation rates among young adult smokers. *Health Psychology, 23*(5), 539-541.

654. 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.

655. 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; McKay, J.R., Lynch, K.G., Shepard, D.S., & Pettinati, H.M. (2005c). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry, 62*(2), 199-207.

656. Stout, R.L., Zwick, W, Lason, M., & Shephard, D. (2001). Case monitoring for alcoholics: One year clinical and health care cost effects. *Alcoholism: Clinical and Experimental Research*, *25*(1), 133-134; Stout, R.L., Zywiak W., & Shepard, D.S. (2003). Case monitoring for alcoholics: Three year clinical and health cost effects. *Alcoholism: Clinical and Experimental Research*, *27*(5, Suppl), 178A; Horng, F.F., & Chueh, K.H. (2004). Effectiveness of telephone follow-up and counseling in aftercare for alcoholism. *Journal of Nursing Research*, *12*(1), 11-20.

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658. Kaminer, Y., & Napolitano, C. (2004). Dial for therapy: Aftercare for adolescent substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(9), 1171-1174.

659. 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.

called report ongoing sobriety, and 78% report attending Twelve Step meetings.[660] Telephone-based support following treatment is also a feature of the continuing care services offered by Hazelden and Caron Treatment Centers.

A peer-based telephone recovery support pilot project has recently been completed by the Connecticut Community of Addiction Recovery (CCAR) and Community Prevention and Addiction Services, Inc. (CPAS). In this model, trained CCAR volunteers met with clients graduating from treatment at CPAS and then monitored their status by phone for 90 days following treatment. Sixty-five individuals received an average of four calls during the pilot, with 29% receiving ten or more calls. At the end of the pilot, 78% had sustained sobriety through this vulnerable period, while those who had relapsed were re-linked to treatment and/or recovery mutual aid groups.[661]

One recent innovation in post-treatment support has been the use of interactive voice response (IVR) programs. IVR systems allow clients to call in daily and respond to automated voice prompts asking key questions related to their mood and activities, leave voice messages, or have a call forwarded to their counselor or case manager.[662] IVR program participation rates can be enhanced by automated phone prompts or personal calls from counselors in response to failure to call the IVR 1-800 number.[663] Telephone-based continuing care and IVR systems may be particularly well-suited for media for continuing care with adolescents.[664] Using an IVR system as a tool of post-treatment continuing care with programmed early intervention responses would seem to have great utility for the future. Both the Addiction Severity Index and the Teen-Addiction Severity Index have been recently adapted and validated for use with IVR systems.[665]

## Advantages of Telephone-based Continuing Care

Telephone-based continuing care support following primary addiction treatment may foster less dependence on the service provider than traditional aftercare programs and be less disruptive to the life of the service recipient (e.g., no travel or childcare concerns or expense, reduced time demands).[666] A recent review[667] noted other potential advantages of telephone-based support (TBS).

- TBS can increase the frequency of support, with easy variability in duration of contact (as little as five minutes), potentially increasing the number of people being served.
- TBS can increase physical safety, where F-2-F services require that clients travel in high-risk environments.

660. Betty Ford Center. (2006). *Focused continuing care: One-year, extended care at Betty Ford Center.* Retrieved on July 30, 2008 from http://www.bettyfordcenter.org/news/innews/narticle.php?id=16

661. Broffman, T., Fisher, R., Gilbert, B., & Valentine, P. (2006). Telephone recovery support & the recovery model. *Addictions Professional,* March-April, Retrieved June 19, 2007 from http://www.addictionpro.com/ME2/Segents/Publications/Print/asp?Module=Publications.htm

662. Hall, J.A., & Huber, D.L. (2000). Telephone management in substance abuse treatment. *Telemedicine Journal and e-Health*, *6*(4), 401-407; Mundt, J.C., Moore, H.K., & Bean, P. (2006). An interactive voice response program to reduce drinking relapse: A feasibility study. *Journal of Substance Abuse Treatment, 30*(1), 21-29; Simpson, T.L., Kivlahan, D.R., Bush, K.R., & McFall, M.E. (2005). Telephone self-monitoring among alcohol use disorder patients in early recovery: A randomized study of feasibility and measurement reactivity. *Drug and Alcohol Dependence, 79*(2), 241-250.

663. Kranzler, H.R., Abu-Hasaballah, K., Tennen, H., Feinn, R., & Young, K. (2004). Using daily interactive voice response technology to measure drinking and related behaviors in a pharmacotherapy study. *Alcoholism: Clinical and Experimental Research, 28*(7), 1060-1064.

664. Kaminer, Y., Litt, M.D., Burke, R.H., & Burleson, J.A. (2006). An interactive voice response (IVR) system for adolescents with alcohol use disorders: A pilot study. *American Journal of Addiction, 15*(Suppl 1), 122-125.

665. Brodey, B.B., Rosen, C.S., Brodey, I.S., Sheetz, B.M., Steinfeld, R.R., & Gastfriend, D.R. (2004). Validation of the Addiction Severity Index (ASI) for internet and automated telephone self-report administration. *Journal of Substance Abuse Treatment, 26*(4), 253-259; Brodey, B.B., Rosen, C.S., Winters, K.C., Brodey, I.S., Sheetz, B.M., Steinfeld, R.R., & Kaminer, Y. (2005). Conversion and validation of the Teen-Addiction Severity Index (T-ASI) for Internet and automated-telephone self-report administration. *Psychology of Addictive Behaviors, 19*(1), 54-61.

666. 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.

667. Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

- TBS can extend services into remote areas where few services are available.
- TBS can be directed to those who have made substantial progress in primary treatment, freeing F-2-F time for those who have not made similar progress in primary treatment.
- TBS might add a potent ingredient to F-2-F contact, resulting in stronger therapeutic alliance, lower dropout rates, and better recovery outcomes.
- Data collected in TBS can also be used to evaluate program effectiveness.[668]

### Internet-based Recovery Support Services

Online services to support addiction recovery have grown in tandem with the rise of the Internet and now include a rapidly growing network of online secular, spiritual, and religious recovery support group meetings; online personal assessment of AOD problems; online therapy; online recovery coaching; and web-based continuing care following discharge from treatment.[669]

There is a growing interest in the potential for Internet-based systems of continuing care. Hazelden, for example, has recently launched a plan to offer all of its patients a web-based continuing care option. This program would combine weekly contacts with a recovery coach with a personalized web-based home page offering learning and self-assessment modules that will guide each individual through early recovery. Unique in this program is a flagging system that alerts the recovery coach of warning signs of relapse revealed in the online self-assessment exercises.[670]

### Summary and Conclusions

Given the overwhelming evidence in support of post-treatment monitoring and support, the addiction treatment field will soon be faced with the question, not whether such services should be provided, but who can best provide these services.[671] There are several choices for such service delivery: 1) the same organization that delivers primary addiction treatment, 2) a peer-based recovery community organization,[672] 3) primary care physicians or local health care clinics, or 4) allied professionals, e.g., interventionists or employee assistance professionals providing this specialty service. It will be important to determine if recovery outcomes differ in general and for specific client populations when post-treatment monitoring and support are offered through these different delivery sites. Further research is needed to clarify whether recovery rates differ by

668. Breslin, C., Sobell, L.C., Sobell, M.B., Buchan, G., & Kwan, E. (1996). After-care telephone contacts with problem drinkers can serve a clinical and research function. *Addiction*, *91*(9), 1359-1364.

669. Kurtz, E., & White, W. (2007). *Telephone- and Internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

670. Duda, M. (2005). Hazelden to launch unique continuing care program. *Hazelden Voice, Summer*. Retrieved on July 30, 2008 from http://www.hazelden.org/web/public/vcsum5contcare.page

671. McKay, J.R. (2005a). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*(11), 1594-1610.

672. 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

the organizational context out of which post-treatment support services are delivered, by professional- or peer-based delivery models, by frequency and duration of support, or by contact media (F-2-F, telephone, Internet), and whether or not variations in effectiveness exist across different demographic and clinical populations.

The most important finding related to early re-intervention following treatment is this: for those individuals who are not abstinent at short-term follow-up following addiction treatment, the best predictor of their abstinence at long-term (five-year) follow-up is readmission to treatment.[673] From an addictions/treatment/recovery careers perspective, the challenge is how to speed re-entry into treatment and other sources of recovery support, to shorten the duration of addiction careers and extend the duration of recovery careers. Post-treatment monitoring and support via recovery management check-ups have been found to speed this re-entry process and diminish the need for future treatment.[674]

Ritsher, Moos, and Finney summarize the emerging view on the importance of post-treatment recovery support services.

> *For this chronic, relapsing disorder, remission tends to be unstable, so the availability of sustained—but not necessarily intensive—therapeutic support is important at each stage of achieving, maintaining, and reestablishing remission.*[675]

## POST-TREATMENT CONTINUING CARE: POTENTIAL STRATEGIES TO ENHANCE RECOVERY OUTCOMES

- Enhance brief interventions in primary care settings with telephone-based interactive voice response post-intervention monitoring.[676]
- Transition from professionally directed treatment plans to client-directed recovery plans.677
- Have each client assess his or her own post-treatment relapse risk level (which is more predictive of actual risk than counselor predictions).[678]
- Give each client choices related to continuing care options and arrange continuing care in congruence with these choices.[679]
- Involve family members in the continuing care planning process.[680]

673. Mertens, J.R., Weisner, C.M., & Ray, G.T. (2005). Readmission among chemical dependency patients in private, outpatient treatment: Patterns, correlates and role in long-term outcome. *Journal of Studies on Alcohol*, *66*(6), 842-847; 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.

674. 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.

675. 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.

676. Helzer, J.E., Rose, G.L., Badger, G.J., Searles, J.S., Thomas, C.S., Lindberg, S.A., & Guth, S. (2008). Using interactive voice response to enhance brief alcohol intervention in primary care settings. *Journal of Studies on Alcohol & Drugs*, *69*, 251-258.

677. Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42.

678. Walton, M.A., Blow, F.C., & Booth, B.M. (2000). A comparison of substance abuse patients' and counselors' perception of relapse risk: Relationship to actual relapse. *Journal of Substance Abuse Treatment*, *19*, 161-169.

679. Brown, T.G., Seraganian, P., Tremblay, J., & Annis, H. (2002). Matching substance abuse aftercare treatments to client characteristics. *Addictive Behaviors*, *27*, 585-604.

680. O'Farrell, T.J., Murphy, M., Alter, J,. & Fals-Stewart, W. (2007). Brief family treatment intervention to promote aftercare among male substance abusing patients in inpatient detoxification: A quasi-experimental pilot study. *Addictive Behaviors*, *32*, 1681-1691; O'Farrell, T.J., Murphy, M., Alter, J., & Fals-Stewart, W. (2008). Brief family treatment intervention to promote continuing care among alcohol-dependent patients in inpatient detoxification: A randomized pilot study. *Journal of Substance Abuse Treatment, 34*, 363-369.

- Adapt follow-up technologies used in longitudinal research to achieve high rates of client participation in post-treatment check-ups and support.[681]
- Conduct further research to evaluate the best media (face-to-face, telephone, Internet, mail), best scheduling formats (frequency and duration of each contact), and the ideal course (span of time following primary treatment) of post-treatment monitoring and support.
- Extend the duration of post-treatment monitoring and support (to include at a minimum an annual recovery check-up) to at least five years following discharge from primary treatment.[682]
- Target those who experience the highest level of craving during treatment for the most extended and intense levels of continuing care services.[683]
- Use personal escorts and financial incentive payments to enhance linkage from inpatient to outpatient treatment.[684]
- Conduct relapse prevention training in a group-based continuing care format.[685]
- Manipulate the post-treatment environment to increase recovery support.[686]
- Provide transitional continuing care orientation and planning groups, to shift from professionally directed treatment to self-managed recovery.[687]
- Use behavioral contracts and calendar prompts to increase participation in continuing care groups.[688]
- Actively resolve barriers to participation, including the need for transportation, the need for child care, and scheduling conflicts.[689]
- Use post-treatment feedback on meeting attendance and telephone prompts to encourage participation in continuing care activities.[690]
- Increase the use of recovery homes and other sober transitional living environments.[691]
- Use e-mail communications to monitor progress between treatment sessions and as a continuing monitoring and support device.[692]
- Provide telephone-based post-treatment monitoring and support.[693]
- Use group-based continuing care followed by telephone support for clients at highest risk of relapse.[694]

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693. McKay, J.R., Lynch, K.G., Shepard, D.S., Ratichek, S., Morrison, R., Koppenhaver, J., & Pettinati, H.M. (2004). The effectiveness of telephone-based

- Use volunteers to deliver post-treatment monitoring and support.[695]
- Use assertive approaches to continuing care that involve case management and linkage to community support systems.[696]
- Conduct quarterly post-treatment recovery management check-ups.[697]
- Provide case management as an alternative to traditional aftercare.[698]
- Use performance measures to improve continuing care, e.g., the Network for Improvement of Addiction Treatment (NIATx).[699]
- Coordinate post-treatment support services across multiple systems of care.[700]
- Involve families in the continuing care service process.[701]
- Conduct home visits in clients' homes using nurses or recovery coaches.[702]
- Conduct treatment follow-up in the workplace via employee assistance professionals.[703]
- Provide structured substance-free leisure activities.[704]
- Expand development of local recovery support institutions, e.g., recovery homes, recovery schools, recovery industries, recovery ministries.[705]
- Provide couples relapse prevention sessions over the course of the year following discharge from primary treatment.[706]
- Enhance continuity of care across all levels of care via provider continuity, maintenance of client contact, linkage to community resources, and coordination of care.[707]
- Link adolescents to aftercare and peer support groups that contain other young people.[708]
- Provide specialized treatment tracks for clients with a history of multiple treatment admissions.[709]

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697. 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; 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.*

698. 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.

## TABLE 10: POTENTIAL RECOVERY-LINKED PERFORMANCE MEASURES

| PERFORMANCE AREA | RECOVERY-LINKED PERFORMANCE MEASURE |
|---|---|
| Post-treatment Continuing Care | Percentage of clients who receive five or more contacts in the first 90 days following discharge<br>Percentage of clients who complete five years of post-treatment monitoring |
| Continuing Care Media | Percentage of clients who receive mailed recovery support flyers<br>Percentage of clients who receive telephone- or Internet-based checkups |

699. McCarty, D., Gustafson, D.W., Wisdom, J., Ford, J., Choi, D., Molfenter, T., Capoccia, V., & Cotter, F. (in press). The Network for the Improvement of Addiction Treatment (NIATx): Strategies to enhance access and retention. *Drug and Alcohol Dependence*.

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703. Foote, A., & Erfurt, J.C. (1991). Effects of EAP follow-up on prevention of relapse among substance abuse clients. *Journal of Studies on Alcohol*, *52*, 241-248.

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# Chapter Fourteen

## Post-treatment Recovery Outcomes

### ■ SUMMARY OF KEY POINTS ■

- Reported treatment outcomes vary by definitions of key measures, e.g., abstinence, sobriety, recovery, lapse, relapse, success.
- Post-treatment evaluations consistently report improved odds of sustained abstinence, reduced AOD consumption by those who use, a reduction in AOD-related problems, and reductions in crime and risk of HIV infection.
- The majority (over half) of people completing specialized addiction treatment in the United States resume some AOD use in the year following treatment.
- Post-treatment relapse rates are higher for men, adolescents, persons dependent on opiates, and persons with co-occurring substance use and psychiatric disorders.
- Between one-fourth and one-third of all clients discharged from addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within two to five years.
- The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admissions, including 22% with three to four prior admissions and 19% with five or more prior admissions.
- Clients discharged from addiction treatment have high post-treatment mortality rates—1.6 to 4.7 times greater than age-matched populations without substance use disorders.
- Stable recovery can be preceded by years of cycling in and out of sobriety experiments.
- Evaluations of specialized addiction treatment also reveal the potential for iatrogenic (harmful) effects of treatment.
- The potential for long-term recovery from substance use disorders is affirmed by population studies noting recovery rates of 50% or higher, but the process of achieving such recoveries is more complex than often portrayed.

Earlier chapters of this monograph have summarized data on the nature of alcohol and other drug problems (particularly the severity, complexity, and chronicity of such problems in clinical populations) and examined process measures that exert influence on long-term recovery outcomes. This review underscored the inability of the acute-care model of addiction treatment to effectively attract, engage, or retain those needing and seeking services or to provide an adequate dose and range of services, link clients to local communities of recovery, or provide recovery-focused continuing care services for the majority of clients. This final chapter presents data that answer the ultimate question: What percentage of clients achieve sustained recovery following treatment within the current acute-care model of addiction treatment in the United States? Any proposal to sustain or to transform the prevailing system of addiction treatment must begin with this question. But for those working on the frontlines of addiction treatment, this may be difficult to answer, in part because most addiction professionals provide services that are only part of a sequenced service process.[710] For example, how do we measure "treatment outcome" for a client whose treatment consisted of a sequence of detoxification, residential treatment, intensive outpatient treatment, outpatient treatment, and continuing care groups provided by different staff and organizations? If there are beneficial or harmful effects of these aggregate services, to which of these services or combinations of services do we attribute the effects?

## Ambiguity of Outcome Definitions

Reported addiction treatment outcomes vary by definitions of abstinence (or sobriety), recovery, lapse, relapse, moderation, controlled drinking, and non-problematic drinking.[711] This makes comparison of outcomes across studies difficult. It is hoped that recent consensus conferences on defining such concepts as *recovery* will improve this situation.[712]

Outcomes vary by developmental age,[713] gender,[714] and ethnicity,[715] and by the presence or absence of co-occurring psychiatric illness.[716] And such outcomes vary by the rigor of the research methodology: in general, reported abstinence rates decline as the follow-up rates increase and the duration of the follow-up period lengthens.[717] In spite of such limitations, several broad conclusions can be stated about what happens to people following addiction treatment.

710. Heinrich, C.J., & Lynn, Jr., L.E. (2002). Improving the organization, management, and outcomes of substance abuse treatment programs. *American Journal of Drug and Alcohol Abuse*, *28*, 601-622.

711. Maddux, F.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; Alemi, F., Haack, M., & Nemes, S. (2004). Statistical definition of relapse: Case of family drug court. *Addictive Behaviors*, *29*, 685-698; Moore, B.A., & Budney, A.J. (2003). Relapse in outpatient treatment for marijuana dependence. *Journal of Substance Abuse Treatment*, *25*, 85-89; 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; Dufour, M. (1999). What is moderate drinking? *Alcohol Research & Health*, *23*(1), 5-14. .

712. 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.

713. 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.

714. 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*, 77-85.

715. Arroya, J.A., Miller, W.R., & Tonigan, J.S. (2003). The influence of Hispanic ethnicity on long-term outcome in three alcohol-treatment modalities. *Journal of Studies on Alcohol*, *64*(1), 98-104.

716. Moos, R.H., Brennan, P.L., & Mertens, J.R. (1994). Diagnostic subgroups and predictors of one year readmission among late-middle-aged and older substance abuse patients. *Journal of Studies on Alcohol*, *55*, 173-183; 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.

717. Harrison, P.A., & Asche, S.E. (2001). Outcomes monitoring in Minnesota: Treatment implications, practical implications. *Journal of Substance Abuse Treatment*, *21*, 173-183.

## Acute and Chronic-care Frameworks of Evaluation

Acute-care interventions are measured by their ability to produce long-term outcomes following a brief period of intervention, e.g., complete "cure" of a bacterial infection following completion of a short course of antibiotics. Chronic-care interventions are measured by their ability to reduce or suppress symptoms while the treatment is underway, without expectation of permanent "cure"; for example, the effectiveness of insulin is measured only for the time period in which insulin treatment is active. It has been suggested that evaluating treatment of severe AOD problems using an acute-care framework rather than a chronic-care framework misjudges the role of professional treatment (and, I would add, of peer-based recovery support groups) in the long-term recovery process.[718]

## Positive Treatment-related Recovery Outcomes

As stated in the opening chapter, addiction treatment has positive measurable effects: the lives of most persons treated will be better after treatment than if they had received no treatment. Post-treatment remissions average about one third of clients discharged, overall AOD use decreases by more than 80% in the months following discharge,[719] and substance-related problems decrease by 60% in the months following treatment.[720] (There are studies reporting continuous abstinence rates higher than one third following treatment, but such studies often have low-below 60%-follow-up rates, and the reported outcomes are based on the percentage of those former clients who could be located and returned a mailed survey or accepted a telephone call, rather than on the total population treated.[721]) Treatment completion is also linked to other gains such as enhancements of global (physical, emotional, relational) health, reductions in injection drug use and sharing of injection equipment, reductions in illegal activity and illegal income, and increases in social stability and productivity.[722] Such gains bolster addiction treatment's claim to legitimacy as a social institution.

New or recycling patterns of drug dependence that emerge (e.g., cocaine, methamphetamine, prescription opiates) are often accompanied by public and professional claims that the casualties of this "new" drug "epidemic" are untreatable, but subsequent scientific studies reveal that participants in these drug surges respond to treatment at levels comparable to earlier clients involved in mainstream treatment.[723]

718. McLellan, A.T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, *97*, 249-252.

719. Reduced use of alcohol and drugs is an often reported (unintended and unexpected) outcome of treatment even within the most abstinence-oriented of treatment programs. See Stinchfield, R., & Owen, P. (1998). Hazelden's model of treatment and its outcome. *Addictive Behaviors*, *23*(5), 669-683.

720. 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.

721. Stinchfield, R., & Owen, P. (1998). Hazelden's model of treatment and its outcome. *Addictive Behaviors*, *23*(5), 669-683.

722. Gossop, M., Trakada, K., Stewart, D., & Witton, J. (2005). Reductions in criminal convictions after addiction treatment: 5-year follow-up. *Drug and Alcohol Dependence*, *79*, 295-302; Hubbard, R.L., Craddock, S.G., Flynn, P.M., Anderson, J., & Etheridge, R.M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, *11*, 261-278; Dismuke, C.E., French, M.T., Salome, H.J., Foss, M.A., Scott, C.K., & Dennis, M.L. (2004). Out of touch or on the money: Do the clinical objectives of addiction treatment coincide with economic evaluation results? *Journal of Substance Abuse Treatment, 27*(3), 253-263; Scott, C.K, Foss, M.A., Lurigio, A.J. & Dennis, M.L. (2003). Pathways to recovery after substance abuse treatment: Leaving a life of crime behind. *Evaluation and Program Planning, 26*(4), 403-412; Gossop, M., Marsden, J., Stewart, D., & Kidd, T. (2003). The National Treatment Outcomes Research Study (NTORS): 4-5 year follow-up results. *Addiction*, *98*, 291-303.

723. Cretzmeyer, M., Sarrazin, M.V., Huber, D.L., & Hall, J.A. (2003). Treatment of methamphetamine abuse: Research findings and clinical directions. *Journal of Substance Abuse Treatment*, *24*, 267-277; Rawson, R.A., Huber, A., Brethen, P., Obert, J., Gulati, V., Shoptaw, S., & Ling, W. (2002). Status of methamphetamine users 2-5 years after outpatient treatment. *Journal of Addictive Diseases*, *21*(1), 107-119.

Reviews of treatment effectiveness typically end with conclusions such as the following:

> *...the findings from this meta-analysis indicate that drug abuse treatment, as it is practiced in the United States, is effective in reducing drug use and crime....it would seem appropriate to cease asking whether treatment for drug abuse is effective and begin asking instead how treatment can be improved and how it can be tailored to the needs of different types of clients.*[724]

When treatment outcomes are evaluated on more than the elimination of pathology, there is evidence that a shift in treatment design might also enhance the quality of life in recovery for many of our success stories. For example, studies of clients with late-onset alcohol problems who achieve successful remission continue to experience depression, chronic health problems, financial and interpersonal stressors, and lower levels of family and social support for the first decade of recovery.[725] Such findings suggest that even our "successes" might benefit from sustained professional monitoring, support, and assertive linkage to professional and indigenous recovery support resources throughout the early years of recovery.

## In-treatment AOD Use

In discussing post-treatment outcomes, it is usually assumed that the biopsychosocial stabilization of clients has been achieved, but the amount of in-treatment AOD use and the degree of such stabilization at the time of discharge have not been subjected to rigorous evaluation. The one study on the prevalence of in-treatment drinking reported that 17% of clients treated in an abstinence-based program drank at least once during treatment, and that 87% of these clients withheld that information from treatment staff for fear that they would be discharged from treatment.[726] What is labeled "relapse" may, for some clients, constitute the continuation of sustained pattern of AOD use that was not interrupted by treatment involvement.

## Post-treatment Lapse/Relapse Rates

The majority (more than 50%) of people completing specialized addiction treatment in the U.S. resume AOD use in the year following treatment,[727] most within 90 days of discharge from treatment.[728] Such use can range between a slip/lapse (single episode of use), a binge (time-limited but high-intensity period of use), a relapse (return of pre-treatment pattern of use), and regression to

724. 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.

725. Schutte, K.K., Brennan, P.L., & Moos, R.H. (1994). Remission of late-life drinking problems: A 4-year follow-up. *Alcoholism: Clinical and Experimental Research*, *18*(4), 835-844; 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., Nichols, K.A., Brennan, P.L., & Moos, R.H. (2003). A ten-year follow-up of older former problem drinkers: Risks of relapse and implications of successfully sustained remission. *Journal of Studies on Alcohol*, *64*, 367-374.

726. Mitchell, D. (2006). Within treatment drinking and surreptitious drinking during brief substance abuse treatment. *Journal of Addictive Disease*, *25*(3), 35-43.

727. Anglin, M.D., Hser, Y.I., & Grella, C.E. (1997). Drug addiction and treatment careers among clients in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 308-323; Institute of Medicine. (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment.* Washington, D.C.: National Academy Press; Wilbourne, P., & Miller, W. (2002). Treatment of alcoholism: Older and wiser? In T. McGovern & W. White (Eds.), *Alcohol Problems in the United States: Twenty Years of Treatment Perspective* (pp. 41-59). New York: Haworth Press.

728. 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.

compulsive use (return or magnification of pre-treatment use-related problems).[729] These variations are often merged under the generic heading of "relapse." Concern about timely responses to post-treatment relapse are underscored by a study of relapse following alcohol dependence that found the median time to re-establishment of dependence following relapse to be 7 days.[730]

Post-treatment recovery rates erode over time for both treatment-naïve clients and clients with prior treatment admissions.[731] The worst post-treatment outcomes occur for those adolescents and adults who presented with the most severe AOD problems before treatment—a finding that would argue for identification and targeting of this group for intensive post-treatment monitoring and support.[732]

## Gender and Relapse

Women begin treatment functioning more poorly than men, but go on to achieve better post-treatment recovery outcomes than men in spite of such obstacles as developmental and adult victimization, greater psychiatric impairment, unemployment, child care responsibilities, and living with another person with an alcohol or drug problem.[733] Post-treatment relapse for women is significantly influenced by living with another person who has an alcohol or other drug problem.[734]

## Adolescent Relapse Rates

First-year post-treatment relapse rates (at least one episode of AOD use) for adolescents range from 60-70%.[735] At least one-third of adolescents leaving treatment relapse in the first 30 days following discharge, and the proportion who relapse increases at each subsequent follow-up point.[736] Within five years following treatment, more than 90% of adolescents will have used alcohol or drugs,[737] with worse outcomes for adolescents with co-occurring externalizing disorders and those who move away from home.[738] When multiple follow-up points are used through five or more years, prior-year abstinence at all points is "rare," although the treatment group shows greater improvement in problem severity than waiting list and control groups.[739] The most common positive treatment outcome is reduction of drinking to non-problematic levels at three-to-five-year follow-up, with this pattern remaining stable for some and later escalating to renewed problem development for others.[740]

729. DeLeon, G. (1996). Integrative recovery: A stage paradigm. *Substance Abuse, 17*(1), 51-63.

730. Besancon, F. (1993). Time to alcohol dependence after abstinence and first drink. *Addiction*, *88*, 1647-1650.

731. 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*(Suppl 1), S13-S22.

732. 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*(Suppl 1), S13-S22.

733. 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*, 77-85; Timko, C., Finney, J.W., & Moos, R.H. (2005). The 8-year course of alcohol abuse: Gender differences in social context and coping. *Alcoholism: Clinical and Experimental Research*, *29*(4), 612-621.

734. 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*(Suppl 1), S3-S12.

735. Brown, S.A., Vik, P.W., & Creamer, V.A. (1989). Characteristics of relapse following adolescent substance abuse treatment. *Addictive Behaviors*, *14*, 291-300; 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.

736. 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: Cambridge University Press.

737. 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*(2), 253-261; Godley, S.H., Dennis, M.L., Godley, M.D., & Funk, R.R. (1999). Thirty-month relapse trajectory cluster groups among adolescents discharged from out-patient treatment. *Addiction*, *99*(Suppl 2), 129-139.

738. 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: Cambridge University Press.

739. 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.

740. Chung, T., Maisto, S.A., Cornelius, J.R., & Martin, C.S. (2004). Adolescents' alcohol and drug use trajectories. *Journal of Studies on Alcohol*, *65*, 105-114.

Adolescents with the poorest treatment outcomes are those with the highest levels of environmental exposure to alcohol and drugs and those least connected to recovery support groups such as AA or NA.[741]

## Relapse and Psychiatric Co-morbidity

Persons with co-occurring substance use and psychiatric disorders can benefit from specialized addiction treatment, but outcomes may be compromised for those with the most severe psychiatric disorders.[742] Persons with PTSD and substance use disorders are less likely to participate in post-treatment continuing care activities and will relapse sooner and use more subsequent inpatient resources than persons with only substance use disorders. Clients with co-occurring psychiatric disorders are less likely to be in stable remission at follow-up after treatment than clients with only substance use disorders, suggesting the possible need for specialized treatment and continuing care strategies.[743]

## Relapse by Primary Drug

Post-treatment relapse rates vary by primary drug. A study defining relapse as four days of use within any seven-day period in the six months following discharge found relapse rates as follows: cigarette smokers, 67%; alcohol-dependent clients, 90%; heroin-dependent clients, 92%.[744] Moore and Budney,[745] using the same definition, found a lapse (any use) rate of 71% for cannabis-dependent clients, with each of these reporting a lapse accelerating to full relapse. Simpson, Joe, & Broome[746] found that 58% of clients treated for cocaine dependency reported prior-year cocaine use at five-year follow-up. Hser and colleagues,[747] in a 12-year follow-up of treated cocaine-dependent individuals, found that 51.9% met criteria for long-term recovery (five years' or more abstinence from cocaine) but many who met this restricted definition of recovery continued to use alcohol and drugs other than cocaine. This pattern of drug substitution has a long history[748] and is a common pattern-particularly when it manifests as the use of alcohol by persons dependent upon drugs other than alcohol.[749]

741. Brown, S.A. (1993). Recovery patterns in adolescent substance abuse. In J. S. Baer, G.A. Marlatt & R.J. McMahon (Eds.), *Addictive behaviors across the life span: Prevention, treatment, and policy issues* (pp. 161-183). Newbury Park, CA: SAGE Publications.

742. McLellan, A.T., Luborsky, L., Woody, G.E., OíBrien, C.P., & Druley, K.A. (1983). Predicting response to alcohol and drug abuse treatments: Role of psychiatric severity. *Archives of General Psychiatry, 40*, 620-625; Moggi, F., Ouimette, P.C., Finney, J.W., & Moos, R.H. (1999). Effectiveness of treatment for substance abuse and dependence for dual diagnosis patients: A model of treatment factors associated with one-year outcomes. *Journal of Studies on Alcohol*, *60*(6), 856-866.

743. Ritsher, J.B., McKellor, 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*(6), 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*, 1300-1311.

744. Hall, S.M., Havassy, B.E., & Wasserman, D.A. (1990). Commitment to abstinence and acute stress in relapse to alcohol, opiates, and nicotine. *Journal of Consulting and Clinical Psychology*, *58*, 175-181.

745. Moore, B.A., & Budney, A.J. (2003). Relapse in outpatient treatment for marijuana dependence. *Journal of Substance Abuse Treatment*, *25*, 85-89.

746. 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.

747. Hser, Y.I., Stark, M.A., Paredes, A., Huang, D., Anglin, M.D., & Rawson, R. (2006). A 12-year follow-up of a treated cocaine-dependent sample. *Journal of Substance Abuse Treatment*, *30*, 219-226.

748. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems; Anglin, M.D., Almog, I.J., Fisher, D.G., & Peters, K.R. (1989). Alcohol use by heroin addicts: Evidence for an inverse relationship. A study of methadone maintenance and drug-free samples. *American Journal of Drug and Alcohol Abuse, 15*(2), 191-207.

749. Ogborne, A.C., & Melotte, C. (1977). An evaluation of a therapeutic community for former drug users. *British Journal of Addiction*, *72*, 75-82.

## Relapse following MMT

Relapse to heroin addiction is high following discharge from methadone maintenance treatment (in a recent study, 73% within 90 days of discharge).[750] This finding will be variably interpreted as a sign of MMT's failure or success, in that, like hypertensive medication, it is effective only during the period of medication adherence. Either interpretation argues for the importance of post-treatment monitoring and support following MMT.

The high relapse rates, particularly for opiate addiction, might be interpreted as evidence that opiate addicts really do not want to stop using, but that interpretation is challenged by continued help-seeking behavior reflected in terms of both attempts at home cure and readmissions to treatment.[751]

## Fragility of Post-treatment Recovery

Individuals leaving addiction treatment are fragilely balanced between recovery and re-addiction in the hours, days, weeks, months, and years following discharge.[752] These individuals are making recovery and re-addiction decisions during a time in which treatment specialists have disengaged from their lives but many sources of recovery sabotage are present. To state that early post-treatment recovery is fragile is not to say that long-term recovery is not possible. The recovery prevalence rate for persons meeting lifetime criteria for substance use disorders ranges between 50-60%.[753] Fifty percent of AA members surveyed report six or more years of recovery,[754] and 51% of people self-identified as "in recovery" in the larger community also report recovery duration of six or more years.[755]

Factors related to post-treatment relapse of adults and adolescents include craving, interpersonal conflict, emotional distress, social pressure to use from peers, exposure to alcohol-/drug-using environments, initial use of a drug other than drug of choice, and a lessening in vigilance and recovery maintenance activities.[756]

Relapse is often embedded in the social interactions that occur after treatment support is withdrawn. There are two dimensions to such interactions: contact and communication with active users and contact and communication with non-addicts. The risk of relapse is high when the former offers a siren call to return to a world where so many of the addict's prior needs were met, and the latter includes expressions of hostility, skepticism, and distrust.[757]

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750. 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.

751. Ray, M.B. (1968). Abstinence cycles and heroin addicts. In E. Rubington & M.S. Weinberg (Eds.), *Deviance: The interactionist perspective.* London: The Macmillan Company.

752. 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*(Suppl 1), S63-S72.

753. Cunningham, J. (1999). Untreated remission from drug use: The predominant pathway. *Addictive Behaviors*, *24*(2), 267-270; 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; Kessler, R. (1994). The National Comorbidity Survey of the United States. *International Review of Psychiatry, 6,* 365-376; Ojesjo, L., Hagnell, O., & Otterback, L. (2000). The course of alcoholism among men in the Lundby Longitudinal Study, Sweden. *Journal of Studies on Alcohol*, *61*, 320-322.

754. Alcoholics Anonymous. (2004). *2004 Membership Survey.* New York: A.A. World Services.

755. 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.

756. Marlatt, G.A., & Gordon, J.R. (1980). Determinants of relapse: Implications for the maintenance of behavioral change. In P.O. Davidson & S.M. Davidson (Eds.), *Behavioral Medicine: Changing Health Lifestyles* (pp. 410-452). Elmsford, NY: Pergamon; Litman, G.K., Eiser, J.R., Rawson, N.S.B., & Oppenheim, A.N. (1979). Differences in relapse precipitants and coping behavior between alcohol relapsers and survivors. *Behavioral Research and Therapy*, *17*, 89-94; Brown, S.A., Vik, P.W., & Creamer, V.A. (1989). Characteristics of relapse following adolescent substance abuse treatment. *Addictive Behaviors*, *14*, 291-200.

757. Ray, M.B. (1968). Abstinence cycles and heroin addicts. In E. Rubington & M.S. Weinberg (Eds.), *Deviance: The interactionist perspective.* London: The Macmillan Company; White, W. (1996). *Pathways from the culture of addiction to the culture of recovery.* Center City, MN: Hazelden.

A meta-analysis of opiate treatment outcome research found post-treatment relapse associated with high levels of pre-treatment drug use, prior treatment, the lack of a prior period of abstinence, abstinence from alcohol, depression, high levels of stress, unemployment, association with drug-using peers, shorter length of treatment, and leaving treatment prior to completion.[758] Alcohol often plays a role in post-treatment relapse, regardless of drug of choice prior to treatment entry.[759]

## Post-treatment Mortality

Individuals with alcohol and other drug problems who seek help for these problems have lower mortality rates than those who do not seek such assistance.[760] In spite of this good news, long-term follow-up studies of treated clients reveal high mortality rates (1.6 to 4.7 times greater) compared to age-matched populations without substance use disorders. These post-treatment deaths primarily are associated with post-treatment relapse[761] and most often are products of accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide, or homicide.[762] Mortality rates revealed in follow-up studies of persons who relapsed after addiction treatment are quite high (21/2 times those of age-matched controls in a 10-year follow-up study),[763] and mortality rates are dramatically increased for tobacco smokers,[764] those with co-occurring psychiatric illnesses,[765] and those who concurrently consume alcohol and/or other drugs following treatment.[766]

Two studies of mortality rates following discharge from methadone maintenance treatment reported an 8% death rate within one year of discharge from MMT in the first study[767] and a 5% death rate at six months following MMT in the second study.[768] The increased mortality rate following cessation of opiate detoxification and drug-free treatment is linked directly to the loss of drug tolerance.[769] Such findings underscore the need for intense post-treatment monitoring, support, and early re-intervention with MMT clients.

The risk of premature death among alcoholics who have achieved stable remission is no greater than that of non-alcoholic control groups.[770] Stable abstinence predicts lower mortality rates, but achievement of lower frequency and quantity of alcohol intake does not.[771] Other factors associated with lower mortality rates include a longer course of treatment, achievement of early abstinence, and longer duration of participation in Alcoholics Anonymous.[772]

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758. Brewer, D.D., Catalano, R.F., Haggerty, K, Gainey, R., & Fleming, C.B. (1998). A meta-analysis of predictors of continued drug use during and after treatment for opiate addiction. *Addiction*, *93*, 73-92.

759. 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*, 107-115.

760. 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.

761. Mann, K., Schafer, D.R., Langle, G., Ackermann, K, & Croissant, B. (2005). The long-term course of alcoholism, 5, 10, and 16 years after treatment. *Addiction*, *100*, 797-805.

762. Hser, Y.I., Evans, E., Huang, D., & Anglin, M.D. (2001). Relationship between drug treatment services, retention and outcomes. *Psychiatric Services*, *55*, 767-774; Hser, Y.I., Stark, M.A., Paredes, A., Huang, D., Anglin, M.D., & Rawson, R. (2006). A 12-year follow-up of a treated cocaine-dependent sample. *Journal of Substance Abuse Treatment*, *30*, 219-226.

763. Edwards, G. (1989). As the years go rolling by: Drinking problems in the time dimension. *British Journal of Psychiatry, 154*(1), 18-26.

764. Vaillant, G.E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*(3), 243-249; Vaillant, G.E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98,* 1043-1051.

765. Fridell, M., & Hesse, M. (2006). Psychiatric severity and mortality in substance abusers: A 15-year follow-up of drug users. *Addictive Behaviors*, *31*, 559-565.

766. Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2002). A prospective study of mortality among drug misusers during a 4 year period after seeking treatment. *Addiction*, *97*, 39-47.

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## Smoking, Relapse, and Mortality

Those with more severe nicotine dependencies have poorer outcomes for the treatment of other drug dependencies.[773] Persons in recovery from alcohol dependence who continue to smoke tobacco are at higher risk of relapse than those in recovery who do not smoke.[774] Smokers treated for alcohol and other drug dependencies also have higher post-treatment relapse rates than non-smokers.[775] Smoking-related diseases constitute a major cause of death for people who have successfully recovered from alcoholism/other drug dependence. Of those discharged from alcoholism treatment, more will later die from nicotine-related diseases than from alcohol-related diseases.[776]

Smoking might exert an independent effect on relapse rates or constitute a hidden marker for psychiatric illness. Indicators such as heavy smoking might be used to identify those individuals at highest risk of post-treatment relapse and mortality and to target such individuals for intensified post-treatment monitoring and support. Studies suggesting that delayed smoking cessation generated better long-term alcoholism recovery rates than concurrent treatment of smoking and other drug dependencies add further weight to this recommendation.[777]

## Rates of Treatment Readmission

Between 25% and 35% of all clients discharged from addiction treatment will be readmitted to treatment within one year, and nearly 50% will be readmitted within two to five years.[778] The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admissions, including 22% with three to four prior admissions and 19% with five or more prior admissions.[779]

Prolonged addiction and treatment "careers" are associated with being male, early age of onset, longer duration of use before first treatment, failure to complete previous treatment, greater problem severity and complexity (e.g., polydrug use), and psychiatric co-morbidity.[780] Compared to first admissions, those readmitted to treatment five or more times are more likely to be unemployed, uninsured, and unmarried; to use opiates; and to have co-occurring psychiatric illness.[781]

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## Cumulative Effects of Multiple Treatment Episodes

The odds of stable recovery increase with the accumulation of years of substance dependence.[782] Sustainable recovery is often preceded by years of cycling in and out of sobriety experiments[783] until multiple interventions generate enough cumulative recovery capital to tip the scales to stable recovery maintenance.[784] The majority of persons who recover from severe and persistent substance dependence do so after multiple treatment episodes occurring over a span of years.[785] However, there is a sizable population of people with three or more treatment admissions who do not improve following additional admissions to treatment as currently designed and delivered.[786]

In a long-term follow-up of those entering treatment in Chicago, the median period from first use to first year of achieved abstinence was 27 years, and the median time from first treatment admission to first year of abstinence spanned three to four treatment episodes over the average course of nine years.[787]

## Iatrogenic Effects of Addiction Treatment

Addiction treatment, like innumerable medical and psychosocial interventions, has the potential for iatrogenic side effects (unintended treatment-caused harm). Harm done in the name of help has a long history in addiction treatment and includes surgical sterilization, lethal withdrawal procedures, prefrontal lobotomies, chemo- and electro-convulsive therapies, and drug insults of innumerable varieties (e.g., treating morphine addiction with pounds of prescribed cocaine in the 1870s).[788]

A recent review of studies reporting iatrogenic effects of addiction treatment concluded that between 7% and 15% of persons treated for addiction deteriorate rather than improve following such treatment.[789] This review noted particular psychosocial techniques that may produce harm (e.g., confrontation, criticism, and other techniques that spark high emotional arousal) and, of particular import to the theme of this monograph, also noted that persons with high problem severity are at high risk of injury when they are assigned to treatments of short duration. The mechanism of such harm appears to be one of demoralization following the escalation of hope.[790] Between 7% and 10% of Project MATCH participants experienced deterioration (substance use levels that exceeded pre-treatment levels) in the three months following treatment.[791] A separate study found that 13% of clients undergoing addiction treatment experienced an exacerbation of psychiatric symptoms

782. 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.

783. Scott, C.K., Foss, M.A., & Dennis, M.L. (2005b). Pathways in the relapseótreatmentórecovery cycle over 3 years. *Journal of Substance Abuse Treatment*, *28*(Suppl 1), S63-S72; 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.

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789. Moos, R.H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction*, *100*, 1240-1248.

790. Moos, R.H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction*, *100*, 1240-1248.

791. Ilgen, M., & Moos, R. (2005). Deterioration following alcohol-use disorder treatment in Project MATCH. *Journal of Studies on Alcohol*, *66*, 517-525.

during the course of such treatment.[792] There are also risks related to medical and pharmacological treatments for addiction. A recent review of pharmacological treatments for opiate dependence noted reports of deaths within 72 hours of ultra-rapid detoxification under anesthesia and the risk of fatal overdose during methadone induction.[793]

Harm can also result from exposure to the treatment milieu, through: exposure to infectious agents; injury or fatality related to seclusion or restraint procedures; financial, emotional, or sexual exploitation; clinical abandonment of clients by professional helpers; or involvement in a therapeutic cult. Concern about this broad span of potential harmful effects of treatment has prompted the development of guidelines that can help addiction professionals prevent such injuries.[794]

## Evaluating and Reporting Local Program Outcomes

Addiction treatment professionals are often asked, "How successful is your program?" Responses to such questions may be drawn from independent studies of outcomes, internal client follow-up reports, estimates based on one's own clinical experience, or program marketing materials. It is not unusual for front-line addiction professionals to wonder why the recovery rates reported by local programs are so high and why those reported in the research literature are so low. The answer lies in the differences in methodologies used to arrive at such rates. The authors of a recent review[795] of such methodologies made the following recommendations to local programs wishing to formally evaluate long-term recovery outcomes of clients they serve.

- Vow to conduct the study in the most objective manner possible, using trained experts in clinical research methods to oversee your procedures from recruitment to treatment to follow-up to analysis and report writing.
- Define the active ingredients of the treatment that is to be evaluated, ensure that staff can and do competently deliver those critical ingredients, and report dosage (i.e., how much of the treatment each participant received).
- Report characteristics of clients upon whose experiences clinical outcomes are based.
- Use the Consort guidelines (http://www.nature.com/bdj/about/Consort.htm) to report client eligibility, recruitment, enrollment, and attrition; remember to use the "intent to treat" standard.
- Use as large a sample as possible, especially if you plan subgroup comparisons.
- Achieve at least an 80% follow-up rate, or be prepared to carefully limit your conclusions.

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792. Ilgen, M., & Moos, R. (2006). Exacerbation of psychiatric symptoms during substance use disorder treatment. *Psychiatric Services*, *57*(12), 1758-1764.

793. Kleber, H. (2007). Pharmacological treatments for opioid dependence: Detoxification and maintenance options. *Dialogues in Clinical Neuroscience*, *9*(4), 455-470; Scott R.T.A., Jay, M.J.H., Keith, R., Oliver, J.S., & Cassidy, M.T. (1999). A confidential enquiry into methadone-related deaths. *Addiction*, *94*(12), 1789-1794; Zador, D., & Sunjic, S. (2000). Deaths in methadone maintenance treatment in New South Wales, Australia 1990-1995. *Addiction*, *95*(1), 77-84.

794. White, W.L., & Kleber, H.J.D. (in press). Preventing harm in the name of help: A guide for addiction professionals. *Counselor*.

795. White, W., & Godley, M. (2005). Addiction treatment outcomes: Who and what can you believe? *Counselor*, *6*(3), 52-55.

- Except for pilot or preliminary investigations, report outcomes for the longest possible period you can afford. One year post-treatment is ideal, but longer is clearly better.
- Validate self-report data with collateral interviews and, whenever possible, chemical testing.
- Use independent interviewers rather than clinical staff who have pre-existing relationships with the study population.
- Evaluate outcomes across multiple dimensions (e.g., changes in quantity and frequency of primary and secondary drug consumption and related problems) and multiple measures of health and functioning, as might be found in the Global Appraisal of Individual Needs or the Addiction Severity Index.
- Be your own worst critic before someone else is—look for alternative explanations for the results obtained, and enlist experienced clinicians to help with this.
- Make all studies upon which success claims are made available for professional and public review.

## Conclusion

The above findings document the frequently long course of substance dependence as experienced by individuals entering specialized addiction treatment in the United States. Great care must be taken in communicating these findings to referral sources, the public, and policy makers.[796] These findings do not support the contention of "once an addict, always an addict" or the charge that recovery is not possible, but they do underscore that recovery is frequently a more difficult, complex, and enduring process than our current treatment design would indicate.

One of the handicaps we are working under in this movement toward a long-term recovery perspective is that the field has a pathology-based and intervention-based foundation of research, but only fragments of research to inform models of long-term recovery and the ways in which such recoveries can best be supported. Initial findings on the neurophysiological processes of addiction recovery are encouraging,[797] but we need much more information to guide the development of stage-appropriate support services over the course of the recovery process. We need a fully developed recovery research agenda whose findings can guide future system-design efforts.

796. Brown, B.S. (1998). Drug use: Chronic and relapsing or a treatable condition? *Substance Use and Misuse*, *33*(12), 2515-2520; White, W., & McLellan, A.T. (in press). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*.

797. Bartsch, A.J., Homola, G., Biller, A., Smith, S.M., Weijers, H.G., Wiesbeck, G.A., Jenkinson, M., De Stefano, N., Solymosi, L., & Bendszus, M. (2007). Manifestations of early brain recovery associated with abstinence from alcoholism. *Brain*, *130*(Pt 1), 36-47.

# Chapter Fifteen

## A Closing Reflection: Recovery, Science, and Systems Transformation

### ■ SUMMARY OF KEY POINTS ■

- Findings from scientific studies and systems-performance data support extending the acute-care model of intervention into severe AOD problems to a model of sustained recovery management.
- The findings support addiction treatment system redesign efforts focused on infrastructure enhancement; early intervention and improvements in service access and therapeutic engagement; improved systems of individual, family, and community assessment; broadening institutional and professional resources involved in service delivery; a shift in the service relationship to a partnership model; elevating the scope, duration, and quality of services; assertively linking individuals and families to communities of recovery; providing post-treatment monitoring, support, and early re-intervention services for all clients/families for up to five years following completion of primary treatment; and the systematic collection of long-term post-treatment recovery outcomes for all clients/families admitted to addiction treatment programs.
- Selected states, local communities, and addiction treatment institutions have already begun this recovery-focused systems-transformation process.
- Model components of the recovery management model (e.g., assertive outreach, enhanced service access, evidence-based service ingredients, and recovery check-up pilots) are already in operation and can be refined for system-wide implementation.
- An existing model of intervention and long-term support that incorporates many dimensions of the recovery management model is the network of Physician Health Programs in the United States, whose evaluations have revealed the highest long-term recovery rates reported in the scientific literature.
- It is time we proactively managed the prolonged course of addiction and recovery careers rather than focusing on self-encapsulated episodes of biopsychosocial stabilization.

## ■ A SUMMARY OF FINDINGS

Scientific research findings reviewed in this monograph support calls for a transformation in the structure and service processes in the United States from a model of acute intervention to a broader model of sustained recovery management. More specifically, the findings call for:

- strengthening the infrastructure of addiction treatment to ensure sustained continuity of support and accountability to the individuals, families, and communities served by addiction treatment institutions;
- more proactive systems of identifying, engaging, and ensuring service access for individuals and families at the earliest possible stage of AOD-related problem development;
- individual, family, and community needs-assessment protocols that are comprehensive, strengths-based, and ongoing;
- the utilization of multidisciplinary and multi-agency service models for supporting long-term recovery for those individuals, families, and neighborhoods experiencing severe, complex, and enduring AOD problems;
- the reconstruction of the service relationship from an expert model to a partnership model involving a long-term recovery support alliance;
- expanding the service menu, with an emphasis on evidence-based and recovery-linked service practices;
- ensuring each client and family an adequate dose and duration of pre-treatment, in-treatment, and post-treatment clinical and recovery support services;
- exerting a greater influence on the post-treatment recovery environment by shortening the physical and cultural distance between the treatment institution and the natural environments of those served, and by intervening directly to increase family and community recovery capital;
- assertive linkage of clients and families to recovery mutual aid groups and other indigenous recovery support institutions;
- models of post-treatment monitoring (recovery check-ups for up to five years following discharge from primary treatment), ongoing stage-appropriate recovery education, sustained recovery coaching, and, when needed, early re-intervention; and
- the systematic and system-wide collection and reporting of long-term post-treatment recovery outcomes for all individuals and families admitted to addiction treatment.

Do treatment programs exist anywhere that share these advocated core elements? Readers who work on the frontlines of addiction treatment will likely recognize treatment programs, including their own, that have developed or are moving toward the development of some of these key dimensions. There are, for example, innumerable leadership and workforce development initiatives under way by federal and state treatment agencies, private foundations, and professional associations, as well as institution-based workforce development efforts. One need only look at CSAT and a growing number of Single State Agencies to see efforts to increase recovery orientation and recovery representation in the field's decision-making. While many states and cities are implementing elements of the RM model, the State of Connecticut and the City of Philadelphia stand as the models for transforming behavioral health care services into recovery-oriented systems of care. These sites deserve extensive study for processes and strategies that can be replicated nationally.

At a programmatic level, there are many community education and outreach programs that could be widely emulated (the many outreach programs for women developed in the past two decades come quickly to mind). Global assessment instruments such as the ASI and GAIN are being used more widely in the field. Programs to increase the use of evidence-based practices are evident in most states. Major advances are being made in communities of color (particularly in Native American and African American communities) in linking addiction treatment to broader cultural revitalization and community development efforts. Many treatment agencies are moving deeper into the lives of their communities via home-based service models, satellite offices, and co-location efforts with other community service organizations. Private sector addiction treatment organizations are conducting research on new models of continuing care. These all represent positive developments, but they constitute silos of innovation within particular settings, rather than system-wide changes. The more important question is whether or not there are any widely disseminated models of service that share many of the characteristics we have identified as essential for systems-transformation efforts.

There are recent program innovations that are worthy of close study. For example, collaborative efforts between addiction treatment and the child welfare system have generated programs that combine aggressive outreach, external coercion, case management, gender-specific treatment of wide scope and long duration, family-based assessment and service design (e.g., parenting training/coaching, child-focused services), assertive linkage to communities of recovery, and sustained post-treatment monitoring and support.[798] Also of historical note is the drug court model, which has been repeatedly demonstrated to increase retention, treatment completion rates, and post-treatment

798. 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.

and post-supervision abstinence rates.[799] If there is one existing system that comes closest to the recovery management model being advocated in this monograph, it is the national network of Physician Health Programs in the United States.

## A Model to Consider

Evaluations of Physician Health Programs (PHPs)—the network of programs sponsored by state medical societies to treat and monitor addicted physicians—report multi-year follow-up recovery rates of 70-96%.[800] The State Medical Society Physician Health Committees established in the 1970s grew into a national network of PHPs that were linked organizationally in 1990 via the formation of the Federation of State Physician Health Programs.

One could quickly argue that any model based on treatment of a high-status occupational group would have little relevance to the mainstream pool of persons entering publicly funded addiction treatment. After all, physicians enter treatment with considerably more recovery capital than most clients entering publicly funded addiction treatment. But before dismissing such potential, one should also consider that studies of physicians entering treatment reveal many factors that would portend a poor prognosis for recovery: family histories of addiction, multiple drug use, co-occurring medical/psychiatric disorders, continual occupational access to powerful psychoactive drugs, elaborate enabling systems, and entry into treatment at late stages of addiction.[801] So what potent ingredients do PHPs possess that offset such risk factors? Key ingredients of PHPs include the following:

- professional education programs that orient physicians to the purpose and elements of the PHP and allow PHP representatives to establish relationships of trust, relationships that attract some physicians prior to formal intervention;
- use of a motivational fulcrum of importance to the client, to initiate and sustain service involvement via contingency management;
- a PHP representative who serves as a combination case manager and recovery coach through the PHP service process;
- referral for a comprehensive (medical, psychiatric, psychosocial, addiction) assessment;
- linkage to a PHP-approved treatment institution;

799. Marinelli-Case, P., Gonzales, R., Hillhouse, M., Ang, A., Zweben, J., Cohen, J., Hora, P.F., Rawson, R.A., & Methamphetamine Treatment Project Corporate Authors. (2008). Drug court treatment for methamphetamine dependence: Treatment response and posttreatment outcomes. *Journal of Substance Abuse Treatment*, *34*, 242-248.

800. Talbott, G., Gallegos, K., Wilson, P., & Porter, T. (1987). The Medical Association of Georgia's impaired physicians' program: Review of the first 1000 physicians—analysis of specialty. *Journal of the American Medical Association*, *257*, 2927-2930; Gastfriend, D.R. (2005). Physician substance abuse and recovery: What does it mean for physicians—and everyone else? *Journal of the American Medical Association*, *293*(12), 1513-1515; Domino, K.B., Hornbein, T.F., Polissar, N.L., Renner, G., Johnson, 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.

801. Domino K.B., Hornbein T.F., Polissar N.L., Renner G., Johnson 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.

- recovery coaching, assertive linkage to peer-based recovery support meetings, and exposure to recovery role models of similar background;
- recovery-focused lifestyle modifications (e.g., personal/family lifestyle modifications), a change in medical specialty, prescribing restrictions, external monitoring of prescribing practices, or a change in institutional affiliation or work schedule;
- long-term (five years and longer) monitoring via urine testing and documentation of continuing care and peer-support participation; and
- aggressive early re-intervention at a higher and more prolonged level of care in response to a positive urine screen.[802]

It is noteworthy that PHPs constitute, not a treatment model, but a model of managing the long-term course of recovery.

In a recent and the most comprehensive (49 states) survey to-date of PHPs, high recovery rates of physicians involved in PHPs were supported by comprehensive assessment; a substantial dose of inpatient (30-60 days) and outpatient (60-90 days) treatment; involvement of family and colleagues in the treatment process; participation in Twelve Step support groups; and five years of extended monitoring (drug testing) and support, including an aggressive early response to any lapse or relapse.[803] The percentage of positive drug tests in the sample surveyed was 0.54%, and 78% of physicians did not test positive once during the multi-year course of their monitoring.[804]

This monograph has outlined the scientific conclusions and the systems-performance data supporting extension of the acute-care model of addiction treatment to a model of sustained recovery management. Elements of such a model have already been shown to enhance long-term recovery outcomes, and programs like the PHPs are demonstrating that these elements can be combined and sustained to generate exceptionally high rates of long-term recovery. It is time we proactively managed the prolonged course of addiction and recovery careers and stopped focusing on brief episodes of biopsychosocial stabilization. It is time for national, state, and local initiatives to create recovery-oriented systems of care that can promote this model of sustained recovery management within addiction treatment programs across the country.

802. 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.

803. DuPont, R.L., McLellan, A.T., Carr, G., Gendel, M., & Skipper, G. (in press). How are addicted physicians treated? A national survey of physician health programs. *Journal of Substance Abuse Treatment*.

804. DuPont, R.L., McLellan, A.T., White, W.L , Merlo, L.J., & Gold, M.S. (2007). Setting the standard for recovery: Physicians Health Programs. Presented at the Betty Ford Institute Consensus Conference: Extending the Benefits of Addiction Treatment: Practical Strategies for Continuing Care and Recovery, October 3-4, 2007, Rancho Mirage, CA.

# Epilogue

The Great Lakes and the Northeast Addiction Technology Transfer Centers (ATTCs) again join to bring addictions and recovery workers and leaders worldwide what we believe to be best thinking on the critical topic of "Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices."

The completion of this monograph is the fifth effort in an ongoing series that will build and allow us to suggest better ways to carry our life-saving work to frontline staff and leaders working to build recovery and recovery-based models of care for those seeking help. As Dr. Evans notes in his Prologue, this is indeed a "seminal" event.

As ATTCs, we sincerely acknowledge and thank SAMHSA/CSAT for the opportunity that has allowed us to complete this important work. We would also like to thank our parent organizations, the Jane Addams College of Social Work, University of Illinois at Chicago (Great Lakes ATTC) and the Pittsburgh, PA-based Institute for Research, Education and Training in Addictions (Northeast ATTC), for recognizing the value of this material and providing the funding and/or resources to produce it. Most important, we are grateful to William White, author of this monograph, for his truly inspired scholarship and dedicated lifelong efforts to bring recovery and its "emerging science" to us all.

Earlier monographs addressed some of the formative issues surrounding the science of treatment and recovery. Indeed, while a few major researchers have longitudinally studied recovery and what might contribute to it, there has been no cohesive body of work that describes what can best lead to recovery, for whom, when, and how. In short, when someone says, "Treatment works" (and it does), we tend to ask—perhaps silently—"But how did it work this time? For whom? And why?"

As if to prove the simultaneity of "seminal" events, a number have unfolded parallel to this work. For example:

- SAMHSA/CSAT began conducting key Recovery Summits and focus groups across the country that achieved the focused attention of the White House in September, 2007.
- The Robert Wood Johnson Foundation launched its Advancing Recovery Initiative to better learn, among other things, how to support recovery in treatment, while SAMHSA/CSAT sought to improve the availability of such care through its Access to Recovery grants.

- Not by coincidence, states such as Connecticut, New Mexico, Alaska, Arizona, Florida, North Carolina, and New York and major cities like Philadelphia (home of Dr. Evans), Seattle, and Detroit have launched sweeping changes to their treatment approaches, incorporating into those approaches treatment recovery principles and supports, peer mentoring, recovery-specialized competencies/credentials, and new program designs.
- In Philadelphia on May 1st and 2nd, 2008, the Institute for Research, Education and Training in the Addictions hosted a Symposium entitled "Aligning Concepts, Practice, and Contexts to Promote Long-Term Recovery," co-sponsored by the Northeast and Great Lakes ATTCs, the Philadelphia Department of Behavioral Health/Mental Retardation Services, Faces & Voices of Recovery, Community Care Behavioral Health Organization, and Gateway Rehabilitation Center. The Symposium featured Bill White discussing this work and presentations by the foremost authorities and diverse leaders on recovery-oriented systems of care, and structured discussions to move the field forward. (For presentation materials or to view a video of the event, click on www.ireta.org/ireta_main/recovery-symposium.html.
- The SAMHSA/CSAT ATTC National Office and Network in July, 2008 launched a new web site with a special section devoted entirely to listing recovery resources. It can be seen at: http://www.attcnetwork.org/learn/topics/rose/resources.asp.
- A leading researcher, Alexandre Laudet, PhD, with the input of individuals from the recovery community, treatment providers, and researchers, produced a document (available at www.ireta.org ) that calls for the now-needed additional scientific answers to questions submitted by these different stakeholder groups. Dr. Laudet's work is very relevant to this monograph, in which Mr. White sets forth a scientific rationale and framework that explains why and how today's clinical practice must have a broader perspective and the increased levels research needed to fully understand and convey the process of "healing" from addiction.

These are especially salient issues, since addiction treatment is often criticized and highly stigmatized. Both the criticism and the stigma could be mitigated somewhat if current practice were backed by a 21st-century science that integrates the best thinking in addressing chronic illness and, most important, includes the lived experiences of those in recovery. Mr. White and Dr. Laudet document well how this approach and the accompanying expanded understanding of treatment and recovery, based on significant early findings, promise to help practitioners in the field use science to better address the illness—and its recovery.

With our vision now focused on treatment and recovery and becoming grounded in scientific evidence, we can begin to see an emerging unified science, instead of science constricted at its base that does not adequately explain or describe the work, experience, and ultimate goal of treatment-recovery! Nevertheless, we must proceed with caution, as we still have much to learn, expectations are high, and resources are scarce. The scientific rationale in this monograph provides a foundation that can be used to pave the way along the path toward systems and clinical change that will document and support the success of new, promising practices and provide the context in which many more individuals and their families will have the opportunity to recognize, achieve, and maintain long-term recovery.

If you have read this monograph, it likely provoked strong reactions, or at least some thoughtful reflection. You may have compared it to your own work or experience and, based on that perspective, confirmed or challenged the validity or worth of this document. Whether you agreed or disagreed with the publication, we have achieved the goal of provoking that thought and experience—one of the main goals of this monograph and of those yet to come. Another equally important goal of this monograph is to set a foundation upon which researchers and practitioners can now further explore, verify, and confirm issues of implementation and aspects of defining and 'languaging' this new science, both quantitatively and qualitatively. This is indeed an amazing challenge and opportunity. This is an amazing time.

This is what we now know, but what is done with it will be up to you. Thanks to Mr. White's work, we have a solid foundation, and our vision of the future is much clearer.

**Lonnetta Albright**
Director
Great Lakes ATTC

**Michael T. Flaherty, PhD**
Principal Investigator
Northeast ATTC

August, 2008




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.

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## Executive Summary: Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices

**William L. White**
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**Prologue by Arthur C. Evans, PhD Epilogue by Lonnetta Albright and Michael Flaherty, PhD Introduction**

For the past decade, I have penned articles for Counselor that called for a fundamental redesign of addiction treatment. That redesign would extend treatment from an acute—an ever briefer--model of biopsychosocial stabilization to a model of long-term recovery management. Through the support of the Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services, I have completed a review of the scientific evidence supporting this recoveryfocused transformation of addiction treatment and outlined the changes in clinical practice suggested by this research. The findings and recommendations are now available in a 138-page monograph that includes a prologue by Arthur C. Evans Jr., PhD, an epilogue by Lonnetta Albright and Michael Flaherty, PhD, and more than 800 research citations. A free PDF of the monograph for downloading and hard copies for purchase are available at www.ireta.org. The new monograph:

- defines and distinguishes acute care and recovery management models of addiction treatment,
- defines and distinguishes the terms recovery management and recovery-oriented systems of care,
- identifies recovery-focused performance measures (e.g., access, engagement, retention, service scope, service duration, linkage to communities of recovery, and post-treatment monitoring and support) that can be used to evaluate addiction treatment as a system of care and evaluate the performance of local organizations specializing in the treatment of severe alcohol and other drug (AOD) problems,

- presents findings from studies of addiction treatment and from national and state addiction treatment data collection systems related to the identified performance measures,
- highlights promising practices aimed at improving long-term recovery outcomes, and
- suggests measures that can be used to evaluate addiction treatment at both macro (system of care) and micro (individual program/unit/worker) levels of performance.

What follows is an executive summary of this monograph prepared for the readers of *Counselor*. I hope it will provide an opportunity to reflect on your own understanding of addiction treatment and recovery. I also hope it will stir sustained discussion and debate and spark new initiatives to widen the pathways to recovery for those individuals and families who are still suffering.

## Executive Summary

### Chapter One Modern Addiction Treatment: Emergence and Evolution of an Acute Care Model

- Addiction (severe alcohol and drug dependency) shares many of the defining characteristics of chronic primary illnesses, e.g., 2 diabetes mellitus, hypertension, and asthma.
- Characterizing addiction as a chronic illness does not mean that all AOD problems have a prolonged course requiring professional treatment, that full recovery is not possible, or that self-management responsibilities are in any way diminished.
- Although long characterized as a chronic disorder, addiction has been treated in an essentially acute care (AC) model of treatment.
- The AC model of addiction treatment is characterized by its crisislinked point of intervention, brief service duration, singular focus on symptom suppression (achievement of abstinence), professionally dominated decision-making, complete post-treatment termination of the service relationship, and expectation for full and permanent problem resolution following “graduation.”
- The development of the modern AC model of addiction treatment grew out of the medicalization, professionalization, and commercialization of addiction treatment and the subsequent growth of managed behavioral health care in the United States.

### Chapter Two: The Momentum for Change

- The AC model of specialized addiction treatment has measurable positive effects when compared to no intervention or alternative nonspecialized interventions, but these effects vary widely by program, counselor, and population served.
- A growing body of outcome data suggests that marketing of the AC model has oversold what individuals, families, and referral sources can expect from a single episode of brief, specialized treatment of severe AOD problems.
- Challenges to the AC model and calls for a more sustained recovery management (RM) model have come from multiple sources: a new grassroots recovery advocacy movement, disillusioned purchasers of care, research data on limitations of the AC model, positive evaluations of RM model components (e.g., recovery checkups), and from excitement generated by recent “recovery-oriented systems transformation” pilots, e.g., State of Connecticut and City of Philadelphia.
- “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.
- "Recovery management" (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

**Chapter Three: Recovery-focused System Performance Measures**

- Interest is rapidly growing in the development of formal, systemslevel performance measures for addiction treatment.
- Recovery-focused performance measures include three dimensions of systems evaluation: 1) measures of infrastructure stability and adaptive capacity, 2) recovery-focused service process measures, and 3) long-term recovery outcome measures.
- Infrastructure stability and adaptive capacity reflect the capacity of an organization to undergo systems transformation processes (e.g., from an AC to an RM model of care) and the capacity of an organization to fulfill its commitment for continuity of contact and support over time to individuals and families seeking long-term recovery.
- Recovery-oriented service process measures are intermediary outcomes (e.g., early identification, engagement, service retention, etc.) that are linked to the final goal of long-term individual and family recovery.
- Long-term recovery outcomes measures represent the major fruits of recovery, defined here as the resolution of alcohol and other drug problems; the progressive achievement of global (physical, emotional, relational) health; and citizenship (elimination of threats to public safety; life meaning and purpose, self-development, social stability, and social contribution).
- Summary: Recovery-Focused System Performance Measures I. Infrastructure Strength and Adaptive Capacity A. Recovery Representation/Orientation B. Organizational Health and Stability C. Health and Stability of Administrative/Clinical Leadership D. Cultural/Political Status E. Capitalization, Funding Diversification F. Availability of Funding Streams for Sustained Support G. Financial Stewardship H. Institutional Relationships I. Workforce Composition and Stability J. Technological Capabilities K. Adaptive Capacity
- II. Recovery-focused Service Process Measures A. Treatment attraction and access B. Screening, assessment, and level of care placement C. Composition of the service team D. Service relationship (engagement, retention and discharge status) E. Service dose, scope, and quality F. Locus of service delivery / Influence on the post-treatment recovery environment G. Assertive linkage to communities of recovery H. Post-treatment monitoring, support, and early re-intervention
- III. Recovery Outcome Measures A. Pre-post treatment changes in: AOD use/consequences, Living environment, Physical health and health care costs, Emotional health, Family relationships and family health, Citizenship (legal status, education, employment, community participation, community service), and Quality of life (spirituality, life meaning, and purpose) B. Post-treatment Service/Support Utilization Patterns, Utilization of professional services, Utilization of indigenous recovery support institutions C. Changes in Family and Community Recovery Capital

**Chapter Four: The Infrastructure of Addiction Treatment**

- Measurable elements of addiction treatment infrastructure required to fully implement a RM model include recovery orientation and representation, leadership stability, an esteemed status of addiction treatment as a cultural and community institution, capitalization and funding diversification, availability of funding streams for sustained recovery support, financial stewardship, organizational stability, workforce stability, technological capabilities, and adaptive capacity.
- Recovery advocates perceive a historical weakening of the recovery orientation of addiction treatment programs; in their view, addiction treatment has become detached from the larger and more enduring process of long-term recovery.
- The extension of the AC model of treatment to a RM model will require repositioning addiction treatment as a cultural institution and re-educating the public and policymakers about the nature of addiction and its treatment.
- The shrinking proportion of health care resources devoted to addiction treatment and the growing reliance on governmental funding for treatment will limit the resources, and demand effective stewardship of the resources, that can be mustered to support systems transformation efforts.
- The move to a RM model will require substantial changes in funding policies and mechanisms to facilitate the development of long-term recovery support services.
- Challenges to systems transformation efforts include the instability of addiction treatment organizations, the mass exodus of long-tenured leaders within the addiction treatment field, and the lack of systemwide programs of leadership development and succession planning.
- Assuring continuity of contact in long-term recovery support relationships will require reversal of the currently high annual turnover rate of the addiction treatment workforce.
- Efforts to create ROSC and to shift local treatment agencies toward a RM orientation will require tandem efforts to strengthen the national infrastructure of addiction treatment in the United States and the infrastructures of local addiction treatment service providers. Lacking such efforts, ROSC and RM will constitute only a new rhetoric and isolated pockets of innovation rather than a true transformation of the system of care.

**Chapter Five: Who Receives Addiction Treatment? The Variability of AOD Problems and Their Patterns of Resolution**

- There are marked differences between AOD problems as seen in the larger community and those seen in specialty-sector addiction treatment settings.
- Those with AOD problems seen in clinical settings are marked by greater personal vulnerability; greater problem severity, complexity, and chronicity; and less recovery capital.
- Strategies of natural recovery, moderated resolution of AOD problems, and resolution of AOD problems through brief intervention that are quite viable in community populations have less utility with the clinical population now entering addiction treatment in the United States.
- The effective treatment of AOD problems requires a clear formalization and delineation of strategies distinguishing transient and less severe AOD problems from AOD problems of great severity, complexity, and chronicity.
- The most fundamental issue facing the field of addiction treatment is whether the field claims ownership of all AOD-related problems (and changes its treatment philosophies and service practices to fulfill that claim) or claims only a portion of AOD-related problems

(e.g., only substance use disorders or only substance dependence), leaving less severe AOD problems to other social institutions. Chapter Six Treatment Attraction and Access

- Only 10% of persons meeting criteria for a substance use disorder receive specialty sector addiction treatment in any year, and only 25% of persons meeting criteria for a substance use disorder will receive such specialized treatment in their lifetime.
- Multiple factors impede help-seeking for AOD problems: misperceptions of the severity of AOD problems; misjudgments regarding self-capabilities to resolve AOD problems, the cost of professional treatment, treatment-related social stigma, the lack of critical treatment supports such as transportation or day care, and resistance to complete abstinence as the only proffered treatment goal across levels of problem severity.
- The AC model voluntarily attracts only a small percentage of persons admitted to addiction treatment, with most persons entering treatment under external coercion at a late stage of problem development.
- High pre-treatment dropout rates (initial contact without service initiation—ranging from 25-50%) are linked to personal ambivalence, lack of geographical or financial access, waiting lists, and personal obstacles to participation.
- Promising practices related to increased attraction and access include social marketing of AOD problem resolution options and successes, assertive models of outreach, lowered thresholds of engagement, interim services for those on waiting lists, short-term case management to enhance engagement, regular check-ups for those resisting immediate service entry, telephone prompts through the early engagement process, family mobilization strategies, extended clinical hours, and delivery of services in non-stigmatized sites.

**Chapter Seven: Screening, Assessment, and Level of Care Placement**

- Early screening and brief interventions for AOD problems are effective strategies of reaching persons with AOD problems who are involved in non-specialized community-based service settings, particularly primary health care settings.
- RM models of assessment differ from the AC models in key dimensions: assessment processes are global rather than categorical; define the individual, family, and community as the unit of assessment rather than just the individual; are asset-based rather than problem- or deficit-based; and constitute a continuing process rather than a point-in-time (intake) event.
- Where level of care decisions in the AC model focus primarily on problem severity and complexity, such decisions in the RM model are heavily influenced by the assessment of personal, family, and community recovery capital.
- Promising practices related to screening, assessment, and placement include AOD problem screening in primary care settings, internetbased screening services, use of standardized global assessment instruments, family-focused assessment protocol, and regular community-level recovery resource mapping.

**Chapter Eight: Composition of the Service Team**

- The extension of AC models of addiction treatment to RM models involves increased involvement of medical, psychiatric, and other allied professionals and the development of peer-based recovery support services.
- There are a growing number of individuals and families with long, complex service careers within multiple systems who, despite the massive investment of dollars in crisis stabilization, exhibit minimal progress towards long-term recovery.

- RM models of care emphasize multi-agency models of intervention and embrace a larger goal of breaking intergenerational cycles of problem transmission, thus providing a framework for the integration of primary prevention, early intervention, treatment and long-term recovery support strategies.
- Promising practices that enhance service team composition include providing primary medical/psychiatric care in tandem with addiction treatment; the use of recovery coaches to provide continuity across levels of care; increased use of volunteers; and the creation of multiagency, multi-disciplinary service teams.

**Chapter Nine: Service Relationship (Engagement and Retention)**

- Pre-treatment dropout rates in addiction treatment exceed 50% of those who initially call regarding services.
- Less than half of persons admitted to addiction treatment successfully complete treatment.
- The percentage of clients administratively discharged from addiction treatment, most for confirming their diagnosis (using alcohol or other drugs while in treatment), has ranged from 10-16% in recent years— between 200,000 and 320,000 individuals per year.
- Those persons who do not complete addiction treatment, both those who drop out and those who are extruded, include those who are in greatest need of such treatment.
- The service relationship in the transition for the AC model to the RM model shifts from that of professional expert to sustained recovery consultant.
- Promising practices in enhancing engagement and retention include the use of motivational interviewing, using senior staff to induct new enrollees into treatment, participation incentives, altering administrative discharge policies and practices, using a choice philosophy to expand the range of client decision-making, increasing the focus on therapeutic alliance in training and supervision, and monitoring engagement indicators by service unit and by individual counselors.

**Chapter Ten: Service Dose, Scope, and Quality**

- Length of service contact is the best single predictor of post-treatment addiction recovery status.
- Length of time in treatment has decreased through the modern evolution of addiction treatment, rendering the service relationship within the AC model of treatment ever more transient.
- The majority of clients discharged from addiction treatment in the United States receive less than the 90 days of service contact (across levels of care) recommended by the National Institute on Drug Abuse.
- Expanding the scope of ancillary medical, psychiatric, and recovery support services in addiction treatment can elevate long-term recovery outcomes, but such service comprehensiveness is not the norm within the addiction treatment service sector.
- Progress is being made integrating evidence-based practices within mainstream addiction treatment, but treatment methods continue that are ineffective or potentially harmful.
- Promising practices related to the dose, scope, and quality of addiction treatment services include greater use of stepped care, more assertive linkage to recovery support groups and post-treatment recovery support institutions (e.g., recovery homes, recovery schools, and recovery ministries), co-location of medical/psychiatric/social services, increased emphasis on evidence-based treatments, increased monitoring of fidelity to preferred

service methods via clinical supervision, and increased communication between clinicians and researchers.

**Chapter Eleven: Locus of Service Delivery Influence on Post-treatment Recovery Environment**

- Most addiction treatment services are institution-based; service providers have little contact with the natural environments of the individuals and families who consume their services.
- Post-treatment family and social environments play significant roles in the long-term recovery process.
- Recovery can potentially destabilize intimate and family relationships that have survived the wounds inflicted by addiction.
- Families can benefit from extended post-treatment monitoring and support.
- Clients deeply enmeshed in drug cultures face special challenges in transitioning from recovery initiation in institutional settings to recovery maintenance in their natural environments.
- Greater attention needs to be focused on the ecology of long-term recovery.
- Promising practices related to locus of service delivery and shaping the post-treatment recovery environment include assertive linkage to communities of recovery, home- and neighborhood-based services, abstinence-based social clubs, recovery support centers, development and/or use of recovery homes and recovery schools, use of indigenous healers and institutions (e.g., folk healers, recovery ministries), and use of consumer council and alumni association members to conduct street outreach and recovery coaching.

**Chapter Twelve: Assertive Linkage to Communities of Recovery**

- Participation in recovery mutual aid groups can elevate long-term recovery outcomes for diverse populations.
- The effects of recovery mutual aid involvement reflect multiple mechanisms of change and vary by the number of meetings in early recovery, duration of participation, and intensity of participation.
- Combining addiction treatment and recovery mutual aid for persons with severe substance use disorders is more effective than either used alone.
- The positive effects of recovery mutual aid groups are compromised by weak linkage and a progressive attrition in participation over time.
- Half of all clients completing treatment do not participate in recovery support groups after discharge, and of those who do, 40-60% discontinue participation within a year of treatment discharge.
- Assertive linkage to a recovery support group is more effective than passive referral (verbal encouragement to attend), but the linkage process in most treatment programs is of the passive variety.
- Participation in other recovery community institutions (e.g., recovery homes, recovery schools, recovery industries, recovery support centers, recovery ministries/churches) may enhance long-term recovery, but evaluation of these other support institutions is at an early stage.
- Promising practices related to linkage to communities of recovery include enhanced institutional linkages between treatment institutions and communities of recovery, use of assertive linkage procedures, orientation and linkage to internet-based recovery support

groups, and expanding treatment philosophies to embrace diverse religious, spiritual, and secular pathways of recovery.

**Chapter Thirteen Post-treatment Monitoring, Support, and Early Re-intervention**

- Post-treatment monitoring and support can significantly elevate long-term recovery outcomes.
- Only a small percentage (20-36%) of adolescents and adults completing addiction treatment receive post-treatment continuing care.
- RM models of continuing care are distinguished from AC models by several critical factors: Post-treatment monitoring and support is provided to all clients, not just those who successfully complete treatment; responsibility for continued contact is with the service staff rather than the client; saturated support is provided in the first 90 days following discharge from treatment; and "recovery check-ups" are provided for an extended period of time (up to five years).
- The timing and duration of post-treatment support exert a greater influence on long-term recovery outcomes than the total number of support contacts or the length of each support contact.
- The telephone and the internet constitute two underutilized media for post-treatment monitoring, support, and early re-intervention.
- Promising practices related to post-treatment monitoring and support include enhancements aimed at participation (behavioral contracts, prompts, escorts, financial incentives), removing barriers to participation, extending time-span of support via recovery check-ups, telephone- and internet-based systems of continuing care, and expanding the range of environments in which continuing care occurs, e.g., home- and work-based follow-up.

**Chapter Fourteen: Post-treatment Recovery Outcomes**

- Reported treatment outcomes vary by definitions of key measures, e.g., abstinence, sobriety, recovery, lapse, relapse, and success.
- Post-treatment evaluations consistently report improved odds of sustained abstinence, reduced AOD consumption by those who use, a reduction in AOD-related problems, and reductions in crime and risk of HIV infection.
- The majority (over half) of people completing specialized addiction treatment in the United States resume some AOD use in the year following treatment.
- Post-treatment relapse rates are higher for men, adolescents, persons dependent on opiates, and persons with co-occurring substance use and psychiatric disorders.
- Between one-fourth and one-third of all clients discharged from addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within two to five years.
- The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admissions, including 22% with three to four prior admissions and 19% with five or more prior admissions.
- Clients discharged from addiction treatment have high post-treatment mortality rates—1.6 to 4.7 times greater than age-matched populations without substance use disorders.
- Stable recovery can be preceded by years of cycling in and out of sobriety experiments.
- Evaluations of specialized addiction treatment also reveal potential iatrogenic (harmful) effects of treatment.

- The potential for long-term recovery outcomes from substance use disorders is affirmed by population studies noting recovery rates of 50% or higher, but the process of achieving such recoveries is more complex than often portrayed.

**Chapter Fifteen: A Closing Reflection: Recovery, Science, and Systems Transformation**

- Findings from scientific studies and systems performance data support extending the acute care model of intervention into severe AOD problems to a model of sustained recovery management.
- The findings support addiction treatment system redesign efforts focused on infrastructure enhancement; early intervention and improvements in service access and therapeutic engagement; improved systems of individual, family, and community assessment; broadening institutional and professional resources involved in service delivery; shifting the service relationship to a partnership model; elevating the scope, duration, and quality of services; assertively linking individuals and families to communities of recovery; providing post-treatment monitoring, support, and early re-intervention services for all clients/families for up to five years following completion of primary treatment; and the systematic collection of long-term, post-treatment recovery outcomes for all clients/families admitted to addiction treatment programs.
- Selected states, local communities, and addiction treatment institutions have already begun this recovery-focused systems transformation process.
- Model components of the recovery management model (e.g., assertive outreach, enhanced service access, evidence-based service ingredients, and recovery check-up pilots) are already in operation that could be refined for system-wide implementation.
- An existing model of intervention and long-term support that incorporates many dimensions of the recovery management model is the network of Physician Health Programs in the United States whose evaluations have revealed the highest long-term recovery rates reported in the scientific literature.
- It is time we proactively managed the prolonged course of addiction and recovery careers rather than focusing on self-encapsulated episodes of biopsychosocial stabilization.

**About the Author**: William L. 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. He has worked full time in the addictions field since 1969.

**Note**: The monograph summarized here was prepared with the support of the Philadelphia Department of Behavioral Health and Mental Retardations Services, the Northeast Addiction Technology Transfer Center, and the Great Lakes Great Lakes Addiction Technology Transfer Center under a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the views of the author and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.



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## The Role of Addiction Medicine in the Transformation of an Urban Behavioral Health Care System

**J. Bryce McLaulin, M.D., Arthur C. Evans, PhD., & White, W. L., MA**

Abstract

*Considerable effort is under way at national, state and local levels to transform addiction treatment and the larger behavioral health care arena into "recovery-oriented systems of care." The emphasis on complex, multi-organization service integration processes, new service roles, and new service delivery sites can obscure the crucial role addiction medicine specialists should play and are playing in such system transformation processes. This article draws from our experiences within the Philadelphia behavioral health system to discuss that role.*

### I. Introduction

There is a long and distinguished history of addiction medicine in the United States. Physicians have played a leadership role in addiction-related policy reform and clinical innovation since the late eighteenth century writings of Dr. Benjamin Rush, advocacy for the creation of inebriate asylums (1830s-1860s), and the subsequent organization of the American Association for the Study and Cure of Inebriety (1870). Physicians have continued such efforts through the twentieth century, particularly through the efforts of such groups as the American Medical Association's Subcommittee on Alcoholism, the American Society of Addiction Medicine (ASAM), and the American Academy of Addiction Psychiatry (AAPAA) (White, 1998; White, in press).

During the modern coming of age of addiction treatment (1970present), physicians have played important roles in drug policy leadership within the White House and at the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the Center for Substance Abuse Treatment (CSAT). Physicians have also led the call for greater neurobiological research on addiction, pioneered improved detoxification protocol, and advocated the use of new pharmacological adjuncts in the treatment and long-term management of addiction.

At a national level, addiction medicine specialists are part of two historical shifts. The first is the emergence of *recovery* as an organizing concept for the design and delivery

of addiction treatment and other behavioral health services (White, 2005). The second is a related call to extend addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (McLellan, Lewis, O'Brien & Kleber, 2000). These twin shifts have sparked:

- Growing interest in recovery research at NIAAA and NIDA,
- New recovery-focused federal services initiatives, e.g., the White House initiated Acces to Recovery Program and CSAT's Recovery Community Services Program.
- State and local recovery-oriented systems transformation efforts
    - (Boyle, 2007, Evans, 2007, Kirk, 2007)
- Private foundation initiatives, e.g., Robert Wood Johnson
    - Foundation's Advancing Recovery initiative, the Betty Ford Institute's consensus conferences on defining recovery and posttreatment recovery support services.

In 2004, the City of Philadelphia launched a major recovery-focused transformation of its behavioral health care system. Table 1 presents several distinguishing elements of what is emerging as the "Philadelphia Model" of behavioral health systems transformation. It can be seen from Table 1 that systems transformation involves fundamental changes in service philosophies and service practices.

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, warmly welcoming and respectful: all system elements are devoted to the goal of rapid and gracious service engagement. |
| 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, genderspecific, culturally competent, trauma-informed, familyfocused 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 summarizes some of the key ideas that guided facilitation of this process of system-wide change.

Table 2: Philadelphia System Transformation Implementation Principles/Strategies

| |
|---|
| 1. Partnership Model: 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.<br>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 all 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 for dramatically magnified effects.

6. Minimalism: Existed structures are used or renewed when possible; the goal is the minimal level of organization needed to achieve a task; wide use of short-term ad hoc groups to study, decide, design, create and disband; preference for use of local expertise.

7. Management of Resistance: Resistance to change at all levels is viewed as normal 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 systems transformation process in Philadelphia is one of aligning system policies and relationships, aligning organizing concepts, and aligning service practices and service policies to support the process of long-term recovery. The history, goals and strategies of this process have been described in earlier publications (Evans & Beigel, 2006; Evans 2007; DBH/MRS 2007a; DBH/MRS/2007b; White, 2007). The purpose of this article is to describe the evolving and anticipated roles of addiction medicine in this ongoing recovery-focused system transformation process.

**Physician Leadership and Systems Transformation**

Physicians occupy key roles in the Philadelphia behavioral healthcare system and in the systems transformation process that is underway. The Medical Director of the Department serves as the lead physician for all the components of the system and as the medical director for mental retardation services. The Associate Medical Director for children and youth oversees activities related to that population throughout the behavioral health components in the system. The managed care component (CBH) has a Chief Medical Officer who has oversight of all clinical activities in that component. Three adult psychiatrists, three child psychiatrists, and three doctoral level psychologists serve as final reviewers for clinical case work in the managed care component.

Physician involvement in systems transformation is based on seven key principles.

1. *Physician leaders can play a critical role as systems transformation advocates and leaders, particularly in elevating and managing quality of care.* Conscious efforts have been made to involve physicians in the systems transformation process as leaders, policy advisers and as role models of recovery-oriented clinical practice. Physicians have also played important roles in program monitoring, training and technical assistance through the transformation process. The Medical Director for the Department has been responsible for establishing an education track in recover for the physicians both within the DBH/MRS and for the psychiatric community at large. The Chief Medical Officer and the physician advisors and psychologists at CBH have played leadership roles in advancing evidence based practice, program monitoring, quality management, and training for the Department and the provider community.

2. *Physician leaders have the responsibility of assuring that quality of direct care is maintained and elevated and that resources are effectively allocated through the systems transformation process*. Leaders in the Philadelphia transformation process emphasized that quality and effective stewardship of resources is even more critical during times of tightening

financial resources. Community Behavioral Health manages care for its membership with an emphasis on the quality of care and ensuring that the membership receives the care that is indicated. 24/7 levels of care and Behavioral Health Rehabilitation Services for children are actively managed. Other outpatient care is not managed. Care managers are Master's prepared individuals who conduct both precertification and concurrent review of care. Some cases require physician/psychologist review and these terminally degreed individuals are available 24/7 for consultation.

3. *Physicians can offer needed expertise on applying principles and techniques of chronic disease management to the addiction treatment context.* Physicians within the Philadelphia behavioral healthcare system have helped shift the focus from intensity of care to extensity of care, legitimize the concepts of "partial recovery" and "medication-assisted recovery" and have offered valuable consultation to clinical directors and frontline clinicians on how to transition from an acute care model of addiction treatment to a model of sustained recovery management.

4. *Physicians are crucial to efforts to build integrated, recoveryfocused treatment systems for co-occurring medical, psychiatric and substance use disorders*. In Philadelphia, physicians have advocated more holistic and continuing client assessment processes, the development of specialized programs for co-occurring psychiatric and substance use disorders, and the treatment of primary medical/health problems within addiction treatment settings or through assertive linkages to primary health care resources.

5. *Physician leaders can play an influential role in wrapping existing and new pharmacotherapies within a larger and more sustained rubric of recovery support services*. That has been achieved by:

- Facilitating the movement of new addiction pharmacotherapies from the arena of clinical research to widespread clinical practice via informal collegial exchanges and formal teaching and consulting related to the role of pharmacological adjuncts in recovery initiation and recovery maintenance,
- Advocating a recovery-focused model of medication-assisted treatment, and
- Conducting regularly meetings with medication-assisted treatment providers to discuss quality of care issues.

6. *Physician leaders need to be intimately involved in discussions of how to move from decision-making models of behavioral health care management that focus solely on managing episodes of care or managing dollars to models that promote assertive management of addiction and recovery careers*. The goals are to escape prolonged patterns of recycling through serial episodes of acute stabilization and to achieve active management of the long-term recovery process. Physicians can offer valuable clinical expertise related to level of care placement, length of stay decisions and appropriate use of service combinations and sequences. The managed care process can be used to transition the focus of providers from on the assertive management or addiction and recovery careers. This process can be enhanced by the development of recovery-focused protocol to guide the decision-making of clinical case managers

7. *An essential component of systems aimed at long-term recovery management is promoting addiction medicine as a legitimate and fulfilling medical specialty*. Toward that end, we are encouraging physician involvement in the promotion of addiction medicine via recruitment, teaching, and mentoring activities. ASAM certified physicians within the DBH/MRS and in the provider community have participated in training the fellows in the University of Pennsylvania's Community psychiatry fellowship.

**System Transformation Leadership Strategies**

In reflecting on our experience with the systems transformation process in Philadelphia, the authors would recommend eight strategies to physicians who wish to play a leadership role in recovery-focused behavioral health systems transformation efforts.

1. Build a foundation of personal/institutional credibility based on fairness, reasonableness, consistency of communication, assertive problem solving, availability, candor and humor. That credibility will be essential for negotiating the multiple partnerships involved in successful systems transformation.
2. Link recovery-focused systems transformation efforts to aspirational values that have long-permeated primary medicine and addiction medicine (for latter, see White, 2008b). We have linked the systems transformation process to high standards of medical and psychiatric practice and as a way for physicians to actualize the early visions he or she hoped to be able to have in the lives of individuals and families.
3. Demystify basic recovery concepts by linking these concepts to existing medical/psychiatric concepts and to physicians' own struggles and life experiences.
4. Develop a recovery education strategy specifically for physicians. Such a strategy should include physicians in system-wide training events and provide training developed exclusively for physicians. The latter should education physicians on the stages and styles of long-term recovery, the empirical evidence supporting models of sustained recovery management, and the changes implicit in the practice of recovery-focused addiction medicine (White, 2008a).
5. Communicate and process the stages of system transformation through regularly scheduled meetings with physicians and other health care providers working at multiple levels within the system. Create time in these meetings for questions and commentary on the progress of systems transformation. Systems transformation is stressful for all involved and is best managed within a supportive environment characterized by transparency and openness of communication.
6. Use local and outside experts to build credibility for system transformation. Bring in leaders in addiction medicine and addiction psychiatry who will both respect and educate the local medical community. Physicians have been under siege from multiple quarters and have witnessed their authority and sphere of practice shrinking. It must be emphasized that recovery-focused systems transformation is not another step in the demedicalization of addiction treatment and that physicians are key to the success of such transformation efforts. Support for transformation efforts increases when physicians can be given tangible tools through which they can integrate a recovery orientation within their service practices.
7. Conduct outreach (site visits) to local service providers with focus on engaging and involving key institutions and institutional leaders in the transformation process. We have found individual meetings with clinical directors to discuss recovery philosophy and to review clinical charts for recovery practices to be very helpful.
8. Provide feedback to physicians on those who do not return and who achieve significant progress or full recovery. Physicians see those who repeatedly re-enter treatment, but often do not see those who achieve successful long-term recovery. We found it very helpful to create opportunities for physicians to witness long-term personal and family recovery, e.g., participating in recovery celebration events and recovery conferences.

**Addiction Medicine and the Future of Addiction Treatment**

We anticipate an increased pace of system transformation efforts in the United States led by state, regional and local behavioral healthcare authorities and supported by grassroots recovery advocacy organizations. Such system transformation efforts will exert a significant influence on the practice of primary medicine and addiction medicine. Primary care physicians will be increasingly called upon to screen their patients for alcohol and other drug (AOD) problems, conduct brief interventions to resolve such problems, assertively link more serious

AOD problems to addiction treatment specialists, and provide recovery check-ups as a routine part of the care of patients with a history of AOD problems. Addiction medicine specialists are playing a critical role in training primary care physicians to perform these screening, brief intervention, and monitoring functions. As primary care physicians become more involved in mild to moderate AOD problems, the addiction medicine specialists are developing greater expertise in the long-term monitoring and support of individuals and families experiencing AOD problems of great severity and complexity. Both primary care physicians and addiction medicine specialists are playing increasingly important roles in local behavioral health transformation efforts. We expect that influence to increase in the coming years.

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## The Role of Partnership in Recovery-Oriented Systems of Care: The Philadelphia Experience

**Roland Lamb, M.A., Arthur C. Evans, Jr., PhD., and William L. White, M.A.**

**Abstract**

*Considerable effort is underway in the United States to transform behavioral health care toward the goal of supporting the long-term recovery of individuals and families. Achieving this goal requires new organizational partnerships, refined strategies of collaboration, fresh approaches to policy and clinical decision-making, and a fundamental restructuring of relationships throughout the system of care. This paper describes the role such partnership processes are playing in transforming addiction treatment in the City of Philadelphia into a recovery-oriented system of care.*

Key Words: Systems transformation, partnership, collaboration, consumer council, faith communities, communities of recovery

### Introduction

The addiction and mental health service fields are undergoing recovery-oriented systems transformation efforts at national, state, and local levels (Anthony, 1993; White, 2005, 2008a, 2008b). Recovery-focused systems transformation is the process through which behavioral health organizations shift their historical focus on acute or palliative care (serial episodes of brief biopsychosocial stabilization or sustained amelioration of personal pathology and its related social costs) toward support for long-term recovery and enhanced quality of personal/family life in recovery. Systems transformation initiatives are dramatically changing service goals and philosophies, funding and regulatory policies, service practices, constituency relationships, and approaches to performance measurement and monitoring (White, 2007a). These efforts are marked by:

- Unprecedented levels of participation of recovering people and their families at all levels of system decision-making
- Increased integration of addiction treatment, mental health, and primary health care
- Integration of professionally-directed clinical services and peer-based recovery support services
- New organizational partners (recovery community organizations, recovery homes, recovery schools, recovery industries, recovery ministries/churches)

- Assertive approaches to sustained recovery management (Anthony, 2000; White, Boyle, & Loveland, 2003, 2004; Davidson & White, 2007; Gagne, White, & Anthony, 2007).

In the City of Philadelphia, a recovery-focused systems transformation process began in 2004 under the leadership of Dr. Arthur Evans, who had helped initiate a similar process in the State of Connecticut. Earlier papers and presentations detailing the goals, strategies, and preliminary outcomes of this "recovery revolution in Philadelphia" address a most basic question: Why would a large behavioral health care system need transforming when it already has its own well-resourced managed behavioral health care organization (over $1 billion a year in revenues), 64 addiction treatment providers operating 182 distinct programs, and a community network of more than 250 recovery homes and more than 800 weekly recovery support group meetings (Evans, 2007; Evans & Beigel, 2006; White, 2007b).

The answer to that question for Philadelphia (and for the rest of the country) is that these valuable resources are simply not enough. Their inadequacy is not rooted in a lack of resources to provide a greater volume of the same services to more clients. It is instead rooted in the basic design of modern addiction treatment. Long-term recovery from addiction can be conceptualized in four broad stages: 1) pre-recovery identification, engagement, and destabilization of addiction; 2) recovery initiation (acute biopsychosocial stabilization); 3) transition from recovery initiation to stable recovery management; and 4) enhanced quality of personal and family life over the course of long-term recovery. At present, addiction treatment in Philadelphia and in the United States devotes nearly all of its resources to the second of these four stages. The treatment system as currently designed facilitates recovery initiation more effectively and more safely than has ever been done in history. What it fails to do as a system of care is voluntarily attract individuals early in their addiction careers, systemically support the transition from recovery initiation to recovery maintenance, and enhance global functioning, citizenship, and life meaning and purpose in long-term recovery. Without significant recovery supports across all four of these stages, addiction treatment as currently designed and delivered fails to assure recovery sustainability for the majority of its clients.

Earlier publications have discussed the why (analysis of systems performance data) and what (needed changes in practice) of the systems transformation efforts that are addressing these design deficits (For a summary, see White, 2008b). This latest work is part of a series of papers focused on the how of systems transformation (also see White,
2008a). This first paper focuses on one particular dimension of the systems transformation process: the strategies used to restructure system relationships and the lessons learned in Philadelphia about this crucial aspect of recovery-focused systems transformation. Here are our reflections and suggestions for others leading such transformation processes.

## Chameleons Change, Caterpillars Transform

Recovery-focused systems transformations involve more than minor refinements to existing models of addiction treatment. Such transformations require a fundamental reconstruction of service concepts, practices, and policies. They start with the realization that no one person, episode of care, system of care, or governmental entity has the resources to support long-term individual and family recoveries for all who need it. Partnerships are fundamental to achieving transformation. We have used the metaphor of the chameleon and the caterpillar to underscore that systems transformation must involve a deep and enduring change in the character and identity of addiction treatment and all of the relationships involved in it rather than superficial commitment to new rhetoric and a few new service appendages.

## Listen to Multiple Constituencies

The first step in systems transformation is purposefully listening to system stakeholders, beginning with its most important constituents—the individuals and families served and individuals and

families who need but have not received services. New leadership of the behavioral health care system in Philadelphia provided a natural opportunity to conduct focus groups to rigorously evaluate the system of care as it existed in 2004. In addition to current and potential service consumers and their families, structured efforts were made to listen to the perceived needs and concerns of those who had worked within the component parts of the Philadelphia behavioral health care system, including staff from key federal and state agencies, representatives from all the existing behavioral health care departments, contracted service providers, recovery advocacy groups, recovery community institutions, leaders from local community centers and the faith communities, and allied service agencies. There were also discussions with the Mayor and other political leaders in the City of Philadelphia about how behavioral health services related to broader community problems, e.g., homelessness, violence, AIDS, and to particular neighborhood development goals.

The City of Philadelphia, like most cities, has a specialized system of addiction treatment, a larger network of allied health and human service agencies, and an even larger network of informal recovery support services (e.g., recovery mutual aid societies, recovery advocacy and support organizations, recovery homes, recovery ministries, etc.). As we listened to individuals representing these three worlds, they portrayed isolated islands connected by drawbridges that remained permanently up, isolating each world from the other. The challenge as it came to be conceived was to connect and align these resources to support long-term recovery for individuals, families, and neighborhoods. What became apparent was that systems transformation must involve not a renewal of addiction treatment as a system of care, but the integration of a renewed addiction treatment into a much larger arena of recovery support. These insights altered the collective vision of the future of addiction treatment and recovery support as well as how system stakeholders viewed each other.

It was not enough to increase the listening stance of DBH/MRS; the challenge was for all of these parties to come together as a listening/learning system of care. That meant that everyone in the system had to increase their listening and learning capacity. The use of skilled facilitators and agendas with structured decision-making steps turned meetings that had been futile exercises in serial speechmaking by the dominant few into discussions in which everyone had an opportunity to speak and where consensus was achieved or key areas of disagreement and choice were identified for further exploration. This listening exercise was extended through the design and delivery of highly participatory, system-wide core recovery trainings. These training sessions provide opportunities for service planners and providers to interact with individuals and families in recovery and to deepen their understanding of the challenges and opportunities encountered in long-term recovery. As of November 2008, 64 Recovery Foundations Training sessions have been conducted for more than 1,600 participants.

## Conduct an Inventory of System Relationships

This listening process came to be thought of as a “searching and fearless” inventory[1] of the existing system of care and of system relationships. Everyone, regardless of their role or tenure within the system, was asked to candidly share their experience within Philadelphia’s behavioral health care system. The stance of all those assigned to conduct these listening exercises was not to defend, rationalize, project blame, or even to correct misinformation. It was to listen, record information provided as accurately as possible, and invite those speaking to enter into a different type of future relationship with the Department of Behavioral Health and Mental Retardation Services (DBH/MRS). That process began in earnest in 2004 and has continued to the present through formal mechanisms that included continued focus groups (with multiple constituency groups), town meetings, meetings with recovery advocacy groups, consumer surveys, and the use of advisory boards and ad hoc committees.

Through this process, people at all levels began to see that the system itself was wounded and was in need of recovery (see below for elaboration of this point). A distinctive aspect of this evaluative

[1] The process was viewed as analogous to Alcoholics Anonymous’ Fourth and Fifth Steps*: 4. Made a searching and fearless moral inventory of ourselves. 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.*

process was the early involvement of recovering people in planning this process through two mechanisms. A Recovery Advisory Committee (RAC) was established that developed a recovery definition, a statement of core recovery values, and a vision document that guided behavioral health systems transformation (see discussion below). The RAC also generated critical input into system change priorities and helped plan peer leadership development initiatives. A second mechanism that assured broad participation in the early needs assessment process was the use of surveys of people in recovery regarding recovery-related needs in Philadelphia. The use of written surveys helped capture information from people who were hesitant to speak in the focus groups.

**Create a Vision of Change**

The listening exercise must be followed by an honest disclosure of system strengths and weaknesses and an inspiring vision of systems renewal or transformation. This occurred in Philadelphia via a series of meetings in which new leadership 1) acknowledged system problems and potentials as perceived by all stakeholders, 2) made a commitment for changing those problems, and 3) invited all stakeholders to participate in mapping out a process of systems transformation. Both local and outside consultants were utilized to create a vision of how core ideas, service practices, and stakeholder relationships would change within a recovery-oriented behavioral health care system. A number of advisory structures were established, including a Recovery Advisory Committee and a number of ad hoc committees that evolved into the Advisory Board of the Office of Addiction Services. These groups helped crystallize and disseminate the emerging vision of the systems transformation process.

**Vision**: An integrated behavioral health care system that promotes recovery, resiliency, and self-determination.

**Mission Statement**: To support people in an environment of recovery, with a focus on prevention, wellness, and self determination to facilitate realizing goals and attaining the highest quality of life possible. We will work with consumers/clients, families, and providers to assure that services are accessible, effective, appropriate, and of high quality. We are committed to develop a system of care that is data driven, employs evidenced-based practices, increases cultural competence, and eliminates health care disparities. This integrated system of care will attend to individual needs and preferences and function in collaboration with a broad range of stakeholders.

This stage involved raising consciousness about recovery, eliciting commitment to a sustained transformation process, and addressing insecurities about the change process and how it would affect individuals and institutions. Budding partnerships were strengthened as key individuals and organizations were involved in planning, hosting, and evaluating the town meetings and conferences that conveyed this new vision. The shared vision was based on an understanding of mutual limitations and collective strength. The central message mirrors the experience of many in personal recovery: “We can achieve together what we could not achieve alone.”

**Develop Consensus on the Need to Move from Power to Partnership (Building a Community of Recovery)**

Through those early listening exercises, it is important to develop a deep understanding of why prevailing relationship patterns within the system of care must be changed. In Philadelphia, review of feedback from the meetings and focus groups revealed a striking image of relationships throughout the behavioral health care system. Power-based relationships that were governed by real or implied threat and control pervaded the system from top to bottom. Whether viewing relationships between federal and state agencies, state and local agencies, agency leadership and direct service workers, or the relationships between direct service workers and clients and families, focus groups revealed an

underlying tone of paternalism, disrespect, and, at times, outright contempt. The theme that emerged was one of a need to control. Clients are controlled by counselors, who are controlled by supervisors, administrators, and boards, who are controlled by state, federal, and private funding and regulatory agencies, who are controlled by the larger political entities to which they are accountable. Competition, conflict, and struggles for status, power, and resources too often colored relationships. With the multiple interests involved, it is easy to see how the focus on the needs of individuals and families can get lost. The restructuring of relationships to emphasize service consumers at the top of this hierarchy or more ideally, to flatten this hierarchy, is a major goal of systems transformation.

Other issues that emerged in focus groups were distrust and "game playing." From clients to macro system administrators, the system consisted of closed tiers with those in each tier viewing the tiers above and below through a perceptual lens of deficits and an attitude of condescension. Such relationships may be inherent within hierarchical systems, but this seems to be magnified in systems dealing with highly stigmatized issues and groups of people. The distrust and disrespect that pervades intrasystem behavioral health care relationships may well reflect the internalization and institutionalization of the social stigma attached to addiction and mental illness. The question raised in the Philadelphia transformation process was how to best move from this atmosphere of power-based relationships toward one marked by deep and sustained respect and collaboration.

As discussions between representatives of DBH/MRS and other system representatives continued and relationships moved beyond role-scripted communications, there was growing consensus that a new recovery-focused philosophy was needed not only for clients and families but for the system as a whole. Several emerging tenets of that philosophy emerged, including the following core ideas:

- We are all wounded (imperfect).
- Both the elements of the service system and the service system as a whole are wounded (imperfect).
- The service system and its practitioners have taken on some of the characteristics of the disorders they are expected to treat, e.g., denial, projection of blame, grandiosity, self-centeredness, preoccupation with power and control, and manipulation.
- We all need to recover—individually and as a system of care.
- We need to recover together.

These points provide a means of escaping the "we-they" polarizations that split communities, professional fields, and organizations into warring camps. They provide an esteem-salvaging answer to the central question underlying resistance to change: "Are you saying that everything I've been doing is wrong?" They create a "we" position from which everyone can acknowledge that the support provided in the past had value but, when provided in isolation, was often ill-timed and sustained for far too short a period of time. These points also helped create a learning community capable of taking the risks inherent in successful transformation. They also openly acknowledge that stakes are high, that hope has been raised, that we are all now invested, and that the costs of failure are very high.

## Develop New Values to Guide System Relationships

To facilitate the healing and renewal of the Philadelphia behavioral health care system, DBH/MRS leadership increased relationship-building activities across the boundaries of system components and sought to model key values that would lead to more supportive relationships between system constituents. The values displayed below were those it was felt DBH/MRS had to exemplify in order to change relationships throughout the behavioral health care system.

**Values Guiding Partnership Development in the Systems Transformation Process**

| |
|---|
| Hope: Sustained recovery and its rewards are possible for individuals, families, neighborhoods, and communities. |
| |
| Respect: Treat all system stakeholders with courtesy and appreciation of their unique strengths and contributions; negotiate rather than dictate; gain trust by giving trust. |
| |
| Strength: Build on existing assets, emphasizing past traditions of commitment, innovation, and excellence; recognize and celebrate transformation efforts. |
| |
| Transparency: Make the criteria upon which decisions are made and the decision-making process visible to all people affected by the decision, e.g., from backroom decision-making to picture window decision-making. |
| |
| Inclusion: Involve the people who will be affected by a decision in the decision-making process; cultivate mutual learning, interdependence, and reciprocity of support. |
| |
| Fidelity: Make only promises you can keep; keep the promises you make. |
| |
| Honesty and Candor: Tell the truth; when wrong, promptly admit it and make amends, e.g., “I made a mistake; it is my responsibility to correct it; I will correct it.” |
| |
| Forgiveness: Expiate and let go of past; expect some regression to old styles of interacting, promptly acknowledge such regression and correct it. |
| |
| Consistency and Endurance: Stay on message and sustain the effort; transformation, like recovery, is not an event but a prolonged process. |
| |

Throughout the systems transformation process in Philadelphia, people were invited to step forward and were provided forums to tell their recovery stories—stories that told how things were, what had happened to change their lives, and what their lives are like now. We tried to emulate that storytelling style by creating a parallel story of how things were for the service system (a rigorously honest account of system assets and aberrations), what happened to spark positive change in the system, and what things are like now. We sought to create a story of how wounded systems can begin a recovery process that parallels the recovery processes of those they serve.

**Begin the Transformation and Partnership Process Internally**

The Philadelphia behavioral health system has rapidly evolved since the closing of the Pennsylvania state hospital system. Prior to 2004, Philadelphia’s behavioral health services were provided through the administrative umbrella of the Office of Behavioral Health and Mental Retardation (OBH) via four distinct organizational units: the Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP), the Office of Mental Health (OMH), Community Behavioral Health (the nation’s first municipalityowned managed behavioral health care organization), and Mental Retardation Services.

In 2004, an executive order was signed and the Office of Behavioral Health and Mental Retardation became the Department of Behavioral Health and Mental Retardation Services (DBH/MRS). A key principle guiding system change in Philadelphia has been that the organization

leading systems transformation must begin the change process internally. That understanding was reflected in the following activities:

- Internal focus groups were conducted about how to more effectively promote recovery orientation within DBH/MRS and the system as a whole.
- Education and training about recovery was required for all DBH/MRS staff.
- Recovery representation within DBH/MRS was increased by hiring people in recovery as DBH/MRS staff and consultants and by recruiting recovery volunteers for DBH/MRS workgroups.
- Cross-unit collaboration via internal workgroups and ad hoc task forces was increased.
- Community representatives were included in internal committees and work groups (e.g., Fiscal, Monitoring, IT).
- Units across the organization were required to develop "unit recovery plans" to identify specific ways their work could be changed as a result of the system moving to a recovery orientation.
- Leadership training.

Within the newly integrated DBH/MRS, the Office of Addiction Services was created (December 2005) to serve as the Single County Drug and Alcohol Authority and to oversee activities related to the funding, coordination, and integration of prevention, screening/assessment, early intervention, primary treatment, and recovery support services. It was in this role that existing partnerships were evaluated and revived and new partnerships were forged.

Much of the early transformation process focused internally on DBH/MRS via increased recovery representation within the DBH/MRS staff, extensive training, and significant input from community constituents on how DBH/MRS polices and practices needed to be re-aligned with system transformation goals. As the transformation process proceeded, each division of DBH/MRS was asked to formulate the role of their unit in the systems transformation process and the activities within the unit that would support the goals and priorities within the transformation process. Each unit plan detailed the internal and external partnerships critical to the plan's success.

**Create Partnership Planning and Advisement Structures**

The behavioral health systems transformation process in Philadelphia required a fundamental reconstruction of all relationships within the service system. The structures created to effectuate this relationship reconstruction included (in the sequence in which they were created): 1) a Recovery Advisory Group (Fall 2005), 2) a Systems Transformation Steering Committee and four issue-specific workgroups (Faithbased/Grassroots Initiative Workgroup, Evidence-based Practice Workgroup, Trauma Workgroup, and Cultural Competence and Health Disparities Workgroup), four ad hoc groups to do systems-level planning related to authorization of care criteria, length of stay criteria, criminal justice/forensic services, and strategic planning. The work of these early groups was then integrated into a newly created Office of Addiction Services Advisory Board in June 2007. The OAS Advisory Board quickly created a Subcommittee on Children and Adolescents. The partnership model that emerged through the work of these structures included six distinct goals.

The first goal was to enhance the partnership between addiction treatment service agencies and the individuals and families they serve. Mechanisms that helped facilitate this partnership included:

- Increasing recovery representation and client representation within addiction treatment agency decision making (e.g., encouraging development of consumer councils, alumni associations, recovery advisory boards, and recovery volunteer programs)
- New service planning frameworks (vision of a rapid transition from professionaldirected treatment plans to client-directed recovery plans)
- Celebrating the role of recovering individuals and families via recovery celebration events, e.g., recovery conferences.

The second goal within the partnership model was to increase partnership activities between addiction treatment providers and between these providers and other community service institutions. Every effort was made to move what had been "backroom" meetings with individual providers to open forums that included all service providers and their representative groups. Joint proposals for multi-agency service projects were encouraged and efforts were made to weaken the competition between providers by celebrating the collective achievements of the provider network. Goal three entailed strengthening the partnership between DBH/MRS, its contracted service providers, service consumers, and local communities of recovery. A key step in this process was the creation of the above-noted structures that allowed input into DBH/MRS policy-making. The work of these groups produced a series of documents (e.g., Blueprint for Systems Transformation, Office of Addiction Services Strategic Plan) that went through extensive stakeholder review and comment before being adopted. Other strategies to enhance the relationships between DBH/MRS and its closest stakeholders included:

- Involving other key organizations in the recovery transformation process, e.g., leaders from criminal justice, child welfare and family services, public health, and homelessness programs
- Visiting grassroots recovery support organizations and rotating meeting locations to increase contact between service organizations and within their natural environments
- Supporting development of the recovery community center as an effort to extend the existing treatment culture toward a broader community of recovery
- Utilizing community reinvestment dollars to fund recovery support services not reimbursable through traditional funding sources.

The relationship between DBH/MRS and its contracted service providers had evolved into an adversarial stance over a number of years. Including individuals and family members in recovery in all advisory groups, meetings, and conferences softened that tension by reminding staff from both DBH/MRS and provider agencies that "This is not really about you." The whole system became much more client-focused through this inclusion and interaction.

As system administrators, we had to shift from a speaking position to a listening position, from a stance of direction to one of facilitation, and from a position of authority to one of true partnership and collaboration. As those relationships were forged one agency at a time, it was also necessary to create rituals that provided an opportunity to set aside "bad blood" that had developed in the past and negotiate new ground rules for proceeding forward. This was not an easy or quick process and entailed much testing and minor and major relapses on both sides. The following mutual understandings and commitments helped:

- We will occasionally regress to old patterns of thinking and acting, and we will continue to make mistakes.
- When wrong, we will promptly admit it, make direct amends, and recommit ourselves to the partnership and the new ground rules.
- We will periodically evaluate the partnership relationship to evaluate the extent to which we are achieving our aspirational values and take action to move us closer to those values.

Greater efforts were also made to conduct regular meetings with all program administrators to insure consistency of communication and their participation in the transformation process.

The fourth partnership goal called upon DBH/MRS to increase its direct contact with indigenous recovery support institutions. It was through this initiative that DBH/MRS began to explore how the resources of other community institutions, (e.g., recovery advocacy organizations, recovery community centers, the faith community, etc.) could be mobilized to help initiate and sustain long-term individual/family recovery. These involvements reminded us that recovery transcends what happens within the walls of a treatment center and helped us visualize a continuum of support that integrated

both professionally-directed clinical services and non-clinical recovery support services for individuals and families.

Goal five involved more closely aligning DBH/MRS goals and activities with the broader community development goals and activities of the City of Philadelphia. The intent was to create a synergy of enhanced impact by aligning multiple efforts. Efforts were made to link our planning efforts to three concerns that were galvanizing the Philadelphia community: 1) homelessness, 2) violence, and 3) the service needs of children and adolescents.

The final partnership goal was to increase recovery community capital in Philadelphia by enhancing the relationship between DBH/MRS and state, regional, and national initiatives. Key activities here included:

- Co-hosting a SAMHSA/CSAT/ATTC/DBH/MRS conference on recovery-focused systems transformation
- Providing training and consultations to other states and cities wishing to emulate aspects of the Philadelphia systems transformation process
- Participating in national efforts congruent with local system transformation goals, e.g., using processes developed by the Network for the Improvement of Addiction Treatment to enhance client access to services, reduce client no-shows, increase admissions to treatment, and enhance treatment retention
- Volunteering Philadelphia as a "laboratory for recovery transformation" to facilitate statewide systems transformation efforts in collaboration with the following state organizations: 1) the Department of Public Welfare Office of Mental Health and Substance Abuse Services, 2) the Department of Health
  Bureau of Drug Abuse Programs and Division of Alcohol and Drug Program
  Licensure, and 3) the Governor's Office of Policy and Planning
- Working to align the state's "Recovering Pennsylvania" initiative and Philadelphia's recovery-focused systems transformation process, e.g., efforts to align policies to support behavioral health service integration via recovery-focused funding policies.

**Create a Transformation Blueprint**

The larger number of activities generated by systems transformation, and the system maintenance functions that must occur simultaneously, can threaten to derail the change process by creating overload and a sense of chaos. Avoiding or managing this potential requires creation of a system transformation blueprint that precisely details the desired and planned changes, when such changes are expected to occur, how such changes will occur, what groups and individuals are responsible for leading each change initiative, and the resources required to implement and maintain each area of change. Early system transformation priorities focused on seven key areas: 1) community inclusion/opportunity, 2) holistic care, 3) peer culture/peer support/peer leadership, 4) family inclusion and leadership, 5) partnership, 6) extended recovery support, and 7) quality of care. How these priorities were to be addressed were set forth in two documents: the recovery transformation blueprint (Fall 2006) and the Addiction Services Strategic Plan (Drafted in the fall 2006 and refined through extensive review and comment through 2007) (see http://www.phila.gov/dbhmrs/strategicplanning/spi_re_intro.html).

The development of a blueprint and strategic goals and objectives provided a means of focusing and integrating existing and new initiatives and provided a conceptual map that helped minimize discouragement about the sheer enormity of what was being attempted. There were numerous points in which energy of groups seemed to wane. Evaluating and recognizing progress being made on the blueprint and strategic plan helped re-energize people. Efforts were made to balance each meeting with a celebration of progress and work on next steps, keeping in mind that systems transformation is a long journey. To acknowledge this, one of the authors (Lamb) developed the ritual of opening or ending each meeting with the mantra, "The struggle continues—The victory is certain!"

## Provide Tools and Contingencies to Support Partnership

Early responses to systems transformation within the recovery advocacy and treatment provider communities went from resistance to skepticism to commitment at a conceptual level, but fears continued about what this would all mean. Historically, the main DBH/MRS partnership was its relationship with its funded treatment agencies. There was some initial resistance from treatment agencies to DBH/MRS's expansion of its partnerships to include such groups as recovery advocacy and support organizations and faith organizations. Treatment providers feared a loss of status and a potential loss of the resources that would be diverted to support these other initiatives.

Those fears and pockets of continued resistance were addressed by: 1) developing consensus on precisely how service practices would change within a recovery-oriented system of care, 2) providing concrete tools to help implement those practices, 3) providing incentives (acknowledgment and funding enhancements) for recovery-focused practice alignment and innovation, and 4) providing technical assistance to organizations having difficulties with the shift in philosophy and practice. Key activities in these areas included:

- Conducting recovery storytelling training to enlarge the number and skills of local recovery advocates
- Involving key treatment providers in the Network for Improvement of Addiction Treatment (NIATx) to enhance local providers' access and engagement protocols
- Working with PRO-ACT to distinguish the roles of sponsor, recovery coach, and addiction counselor
- Working with PRO-ACT to develop ethical guidelines for the delivery of peerbased recovery support services
- Developing new treatment and recovery support approaches via piloting, evaluation, and encouragement for system-wide implementation, e.g., the structure and activities of the NET Consumer Council
- Providing financial incentives to enhance recovery support services within medication-assisted treatment

## Highlight the Fruits of Recovery Partnership

Restructuring behavioral health care systems goals and relationships is rigorous and at times exhausting work. Celebrating the fruits of recovery partnership can help sustain investment in the transformation process. Everyone—from clients to local treatment administrators, from allied agencies to mayors and governors—needs to see and celebrate the fruits of systems transformation. Concrete manifestations of systems transformation in Philadelphia included the following:

- Involvement of national leaders on recovery and systems transformation to motivate and educate local system stakeholders
- Extensive training on trauma, wellness, and recovery and funding of new service initiatives for the integrated treatment of co-occurring disorders
- Recovery celebration events (e.g., marches, conferences) that created a way to honor the efforts of individuals and families in recovery and other individuals and organizations who are playing key roles in the system transformation process
- The opening of Philadelphia's first recovery community center, which served more than 2,300 individuals in its first seven months of operation
- Mini-grants to 65 organizations to enhance their organizational transformation efforts or to seed new recovery support services
- Creation of seven coalitions between community-based organizations and faithbased organizations with behavioral health treatment providers to address prevention and recovery support needs within key neighborhoods within the City of Philadelphia

- A 26-week Peer Leadership Academy through which more than 60 individuals and family members in recovery have been trained to assume leadership roles in Philadelphia's recovery-focused systems transformation process
- A Peer Specialist Initiative through which more than 140 individuals in recovery were trained and hired within the Philadelphia behavioral health care system.

The recovery celebration events in particular provided a vehicle for celebrating personal, organizational, and systems recovery. These events included conferences that brought together recovering people, addiction professionals, and allied service professionals for dialogue; conferences with more than 1,000 attendees that were organized, facilitated, delivered, and evaluated by people in recovery; and large public celebration events such as the 2008 Recovery Walk, which drew more than 4,500 individuals. A pivotal point in the history of systems transformation in Philadelphia occurred when Mayor Michael Nutter stepped to the podium at the March 28, 2008 Recovery Conference to address recovering individuals, family members, addictions professionals, and allied service professionals. When those 1,200 participants stood to see themselves and be acknowledged by local political leaders as "a community," it was a "coming of age" moment for the systems transformation movement in Philadelphia.

**Build Institutional as Well as Personal Relationships**

There is a tendency to grossly underestimate the time that will be required to transform a complex service system. This has important implications for partnership development within systems transformation. More specifically, key institutional partnerships cannot be based solely on the relationships involving a small number of key individuals. What we painfully learned in Philadelphia is that unexpected events such as job re-assignments and prolonged sick leaves can disrupt partnership development when such partnership efforts are based on a small number of key leaders. The lesson here is that partnerships between organizations must be built from the top down and across organizations so that these are institutional relationships rather than person-dependent relationships. Philadelphia, like most cities, also has a core of long-tenured behavioral health leaders who will retire in mass in the next decade. Any partnerships forged as part of the systems transformation process must be able to survive these coming leadership transitions.

**Develop Ways to Measure Partnership**

There are so many simultaneous initiatives occurring within a systems transformation process that it is difficult to see what progress, if any, is being made. Within each partnership structure, we found it helpful to evaluate how we would know if a particular effort was successful. Here are two examples of how this was achieved. When the OAS Advisory Board was established in 2007, we conducted an exercise in which the founding members were asked to fill in the following sentence: *The OAS Advisory Board will be a success if a year from now* _____. Table 1 in the appendix lists the criteria that were generated and the Board's evaluation based on those criteria a year later. We found this process extremely helpful in evaluating the work of the advisory committee based on criteria generated by the committee members themselves. Systems transformation involves significant shifts in policies and practices, and we found it important to help people personalize these needed shifts. One of the methods we used to do this was a series of Tools for Transformation documents. Each of these documents looked at a particular area of service practice, e.g., extended recovery support services, and provided separate checklists through which DBH/MRS staff, service providers, and individuals/families in recovery could evaluate themselves related to this area. All of these checklists evaluated the quality of partnership relationships and offered potential strategies for strengthening partnerships related to each area being evaluated. We are currently developing Report Cards for both DBH/MRS funded organizations and the overall systems transformation effort. We are also currently defining the micro- and macro-level recovery benchmarks to measure systems

transformation and refining data systems to assure that such benchmark data can be consistently collected and analyzed.

## The Stages of Systems Recovery

Prochaska, DiClimente, and Norcross (1992) have outlined a model for understanding the stages of personal recovery. These stages also approximate the stages of recovery-focused systems transformation in Philadelphia as experienced by contracted treatment providers and DBH/MRS staff. Table 2 outlines such changes and the stage-dependent strategies used to move the transformation process forward.

**Table 2: The Stages of Systems Transformation**

| Stage | Attitude toward Overall Systems Transformation | Attitude toward Partnership Development | Core Strategies |
|---|---|---|---|
| **Pre-contemplation** | Program Level: everything is fine; treatment works; we just need more money to do more of what we're currently doing; we are already recovery-oriented; no one will pay for this recovery stuff. Systems Level: | Isolation or limited contact between system stakeholders and between stakeholders and the larger community; tendency to view other stakeholders as "not getting it"; treatment programs and other community agencies | Listening exercises (focus groups with clients/families and providers); education and consciousness raising via charismatic leaders; solicitation of internal and environmental feedback; |
| | System design is fine; we just need to elevate quantity and quality of existing services by providers. | view each other as resource competitors. | promoting strategies of self-evaluation; |

| | | | |
|---|---|---|---|
| **Contemplation** | There are significant problems with the current design of addiction treatment but obstacles to addressing them are insurmountable; recovery-related practice changes considered periodically but lost amidst distractions; efforts lost in culture of low funding, low expectations but high demand for services. | Possible advantages of new partnerships enter organizational consciousness and are periodically discussed without follow through; professionals begin raising questions about ethics of self-disclosure and dual relationships. | Insight development; pro and con analysis of change or no change; use of critical incidents as opportunity for eliciting commitment to change; recovery-focused education and training conducted at conceptual and attitudinal level; insight-oriented interventions; promoting interorganizational boundary transactions; expanding inclusiveness of who is brought to table; e.g., use of national and local recovery advocates to challenge status quo |
| **Preparation** | We have decided and are committed to making major changes in service philosophy and practices to increase long-term recovery outcomes; goals are set to begin this process within the coming year. Still | We have identified key internal and external partnerships that need to be strengthened. We are spending more time in selfevaluation and environmental scanning, but have | Self-assessment and planning tools developed for individuals and organizations; increased availability of training and technical assistance; mutual stakeholder support for |
| | more talk than action. | not moved from planning to implementation. | processing planning activities. |

| | | | |
|---|---|---|---|
| **Action** | We are making recovery-focused changes in service philosophy, policies, and practices. We are moving through superficial changes toward the achievement of substantial changes. Many change-related activities are continuing. The transition from old to new is variably experienced as overwhelming, chaotic, and exhilarating. We decide we cannot do this alone; request and mobilize help and ongoing support. Unit recovery plans developed within DBH/MRS to actualize each unit's role in transformation process. | Intra- and intersystem boundary transactions have increased dramatically; we are involved in multiple internal and external change initiatives; each program/unit contains early adopters and resisters; change process absorbs latent conflict between individuals, units, and organizations; resisters are progressively isolated. | Systems transformation defined in behavioral terms; contingency management—making system rewards contingent on pro-recovery policies and practices; increased availability of training and technical assistance; intersystem transfer of new recovery tools, e.g., mechanisms for recovery representation, recovery planning formats, recovery checkup protocol; focus on getting system aligned, coordinated, and integrated across local, state, and federal levels. |
| **Maintenance** | We have come a long way but still have to catch ourselves when we slide into old patterns of thinking and acting, particularly during periods of distress, e.g., funding crises. | Rituals of regular gathering defined with high level of participation, e.g., advisory council meetings, annual recovery conferences, recovery celebration events. | Procedures for fidelity monitoring and refinements in service philosophies, policies, and practices; continued freshening of celebration and recognition ceremonies; acknowledgment |

| | | | |
|---|---|---|---|
| | | | and visibility, e.g., use of internal leaders as consultants to other communities; pride in whole system as a community of recovery. |

Like individuals in recovery, it is not unusual for systems to cycle through these stages multiple times before achieving a sustained and successful transformation process. The stages involved in partnership development through the systems transformation process are illustrated in the history of the Advisory Board of the Office of Addiction Services. There have been three stages in Advisory Board composition: 1) a balance sought between OAS staff/consultants, providers, people in recovery, and representatives from other systems and city departments, 2) conscious inclusion of child and adolescent advocates, and 3) a move to increase recovery representation. The meeting format transitioned from information dissemination to board discussion and recommendations to OAS to an increased role in OAS decision-making. The planning and facilitation of Advisory Board meetings also went through distinct stages:

1. OAS staff established agenda and facilitated the Advisory Board meetings.
2. OAS staff established agenda and an OAS consultant facilitated the meetings.
3. Stakeholder (provider and recovery advocate) co-chairs established for the Advisory Board.
4. Co-chairs included in agenda setting for all meetings.
5. Co-chairs assumed responsibility for facilitating the meeting, with consultants available to facilitate particular agenda items

Two future steps are planned: 1) training OAS advisory member volunteers in meeting facilitation, and 2) co-chairs facilitating the meeting, with other members facilitating meeting agenda items. The working style of the board has also changed from one of all work being done during the board meeting to workgroups between meetings reporting out and facilitating discussion on key issues. All of these changes reflect concrete ways in which relationships based on power and authority are changing to relationships based on partnership.

**“Deeper and Broader”**

We are four years into the systems transformation process in Philadelphia and are again evaluating our progress to date. As we pull stakeholders together as part of this evaluation process, the theme of “deeper and broader” resounds in meeting after meeting. The “deeper” reflects calls to move the change process and the existing partnership relationships from areas that generated rapid consensus to areas that touch on areas of greater threat to vested ideas and interests. “Deeper” also means that the vision and core values of the change process have been formulated and that it is now time to let that vision and those values permeate all system policies and practices. Moving from small changes to big changes builds momentum and hope for the overall transformation process. It also reflects a larger recovery vision of outward healing from individuals, families, organizations, neighborhoods, and whole communities. In terms of partnership, “deeper” also implies that building partnership relationships is not a task with a defined beginning, middle, and end. These partnership relationships must be regularly fed and deepened or they will die from lack of attention.

The “wider” suggests that not all community stakeholders were equally engaged in the transformation process and that we need to reach out to those groups and bring them into the transformation process. Discussions to date in Philadelphia regularly note that we need to more clearly define and adapt the transformation process for such groups as child and adolescent service providers, medication-assisted treatment providers, and treatment providers closely linked to the criminal justice

system—groups who have not always felt like they were full partners in the transformation process. Similarly, not all units within the Department of Behavioral Health and Mental Retardation Services were equally involved or supportive of the transformation process.

We anticipate that our intensified involvement with these external organizations and internal units will generate new lessons and further refine the transformation process. We suspect that transforming any large, complex behavioral health organization or system will need to unfold in layers and waves. With sustained effort, involvement can be achieved even from those inside and outside the lead agency who believed that recovery-focused systems transformation was a passing fad that they could wait out.

## Summary

In 2005, the City of Philadelphia committed itself to creating a more recovery-oriented system of behavioral health care for its citizens. A central component of this transformation process was the reconstruction of relationships between the multiple stakeholders involved in the City's behavioral health care system. This paper describes the partnership model that has been so critical to the success of work to date toward this goal.

Essential steps in this process included:

- A sustained exercise in listening
- Conducting a self-inventory of the state of system relationships
- Developing the vision of a transformed system of care
- Generating consensus on the need to move toward a partnership-based versus power-based relational model
- Forging consensus on partnership values to which all parties would be accountable
- Beginning the transformation process internally to model commitment to new values
- Creating structures through which new partnerships could be initiated and sustained
- Developing a transformation blueprint/plan that defined goals, roles, and relationships
- Providing tools and contingencies (rewards) for movement toward partnership model
- Visibly celebrating the fruits of transformation and the new partnerships that were created through the transformation process
- Creating institutional partnerships that are not dependent on only a small number of key people
- Recognizing that partnership development will take sustained time and effort and will develop in stages across multiple stakeholder groups
- Measuring system relationships as part of the larger evaluation of system transformation efforts.

Transforming behavioral health care systems involves at its essence transforming the relationships within such systems. It is our hope that other communities can benefit from the Philadelphia experience of how we have attempted to manage the pitfalls and potentials through a sustained transformation process.

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Appendix

Table 1: Department of Behavioral & Mental Retardation Services, Office of Addiction Services Advisory Board, Benchmarks for Success

The members of the OAS Advisory Board identified benchmarks for success during their July 18, 2007 meeting. This worksheet was completed a year later to assess the Advisory Board's progress.

**Please circle the status of the benchmark as:**

**A = Accomplished B = Making progress C = Improvement needed D = Deteriorating E = N/A**

***A year from now, we would have been a successful Advisory Board if we…***

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | have identified a series of concrete, achievable priorities for system transformation and outlined the steps necessary to achieve them and measure their success. | A<br>3 | B<br>4 | C | D | E<br>1 |
| 2. | have developed, implemented, & communicated a strategic plan with a vision, goals, priorities, & strategies of implementation. | A<br>5 | B<br>2 | C | D | E<br>1 |
| 3. | have implemented at least 1-2 new initiatives, either a new program or strategies to enhance/modify existing programs. | A<br>5 | B<br>2 | C | D | E<br>1 |
| 4. | have a plan that is initiated and introduced at a conference for all stakeholders – conference will broadcast the vision and promote change actions by all stakeholders. | A<br>3 | B | C<br>2 | D | E<br>1 |
| 5. | have developed a plan that truly affords barrier-free access to recovery. | A | B<br>5 | C<br>3 | D | E |
| 6. | have followed through with our discussions. | A<br>1 | B<br>6 | C | D | E |
| 7. | are still meeting. | A<br>5 | B<br>3 | C | D | E |
| 8. | have accomplished some of the tasks outlined today (July 18, 2007 orientation meeting), such as addressing issues of line staff by developing more training and reducing the paperwork. | A | B<br>5 | C<br>3 | D | E |
| 9. | have learned from one another how to put people first and ourselves next. | A<br>3 | B<br>6 | C | D | E<br>1 |
| 10. | have an environment where people are receiving better | A | B | C | D | E |
| | services/treatment including compassion and understanding. | <br>1 | <br>5 | <br>1 | | |
| 11. | have an environment where people will have an opportunity to succeed in life. | A<br>1 | B<br>5 | C<br>1 | D | E<br>1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 12. | have put our plans into action. | A<br>1 | B<br>6 | C<br>1 | D | E |
| 13. | have stimulated the production of a working operational plan for OAS. | A<br>1 | B<br>6 | C<br>1 | D | E |
| 14. | have achieved our organizational goal. | A | B<br>8 | C | D | E |
| 15. | have people who have primarily been excluded from addiction services or have been underserved by the system have full and unfiltered access to a fuller continuum of services. | A<br>1 | B<br>2 | C<br>4 | D | E<br>1 |
| 16. | there is evidence of greater collaboration among service systems in terms of actual utilization and service plan achievement. | A<br>1 | B<br>4 | C<br>1 | D | E<br>1 |
| 17. | if 60% of the addiction services providers have adopted or been adopted by a church, mosque, synagogue, or community center that has opened its doors to the consumers. | A | B<br>2 | C<br>4 | D | E<br>1 |
| 18. | have seen more addicts get help and stay clean. | A | B<br>3 | C<br>4 | D | E<br>1 |
| 19. | Have allowed our group conscience to lead and guide us. | A<br>1 | B<br>4 | C<br>1 | D | E<br>2 |
| 20. | have created a vision for a recovery-oriented service system. | A<br>5 | B<br>3 | C | D | E |
| 21. | have a vision that is used to develop a plan to implement the vision (stages of change management). | A<br>2 | B<br>4 | C<br>1 | D | E<br>1 |
| 22. | have a plan with clear bench marks to measure the achievement of each element of the plan. | A<br>1 | B<br>5 | C<br>2 | D | E |
| 23. | have families that are part of the team and allowed to take part in all areas of their child's treatment. | A | B<br>6 | C<br>1 | D | E |
| 24. | have an increased climate of trust and partnership between CBH, providers, and the community. | A | B<br>5 | C<br>2 | D | E |
| 25. | have good programs rewarded and programs that hurt people and refused to change (after much effort on DBH part) are de-funded. | A | B<br>2 | C<br>6 | D | E<br>1 |



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## A Message of Tolerance and Celebration: The Portrayal of Multiple Pathways of Recovery in the Writings of Alcoholics Anonymous Co-Founder Bill Wilson

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

One of the central messages of the New Recovery Advocacy Movement is the declaration that there are many pathways and styles of long-term recovery from severe alcohol and other drug problems. This message is of historical note, but it is not surprising. The recovery advocates who have forged this grassroots movement represent a broad spectrum of religious, spiritual, and secular pathways of recovery and represent quite variable styles of recovery practices within these respective frameworks of recovery (White, 2006, 2007).

Such diversity does not preclude the fact that *the majority* of recovery advocates have past or current affiliation with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or another Twelve Step recovery program. Such backgrounds are not obvious because most advocates with Twelve Step recovery experience, in keeping with Twelve Step traditions, maintain anonymity at the level of press regarding their past or present affiliation with Twelve Step groups. When they stand and speak in their advocacy roles, they do so as *persons in recovery,* not as members of AA, NA, or other Twelve Step fellowships (Advocacy and Anonymity, 2006).

But, given the high representation of people with Twelve Step backgrounds within this movement, how can these recovery advocates' declaration of the legitimacy of multiple pathways of recovery be reconciled with the charges by Twelve Step critics that AA and other Twelve Step groups practice coercive and cult-like indoctrination and a "one size fits all," anti-professional, anti-scientific approach to addiction recovery?[1] Are these recovery advocates heretics within

[1] Such criticism is part of a "backlash movement" against AA, AA-oriented addiction treatment, and the portrayal of addiction as a disease. This backlash movement has its own leaders, celebrity speakers, literature, and websites. This movement rarely distinguishes 12-step groups from 12-step oriented professional interventionists, 12-step oriented treatment, and external authorities who may mandate participation in 12-step groups (e.g., professional licensing boards, judges, probation/parole officers, child welfare agencies.) For representative literature of this movement, see Bufe, 1991; Fransway, 2000; Peele, 1989; Peele, Bufe, & Brodsky, 2000; Ragge, 1998; for

their Twelve Step societies for their support of the legitimacy of multiple recovery pathways? Or have the philosophies of Twelve Step programs toward alternative frameworks of recovery been misrepresented by their critics? This brief essay will explore these questions using the writings of AA co-founder Bill Wilson as a guide to how AA views itself and alternative frameworks of addiction recovery.

Defining what AA does and does not believe or does and does not practice is difficult in light of the variability across Twelve Step programs, the lack of central leadership within such programs, and the varieties of local practices that can be found under the Twelve Step umbrella. We have been struck by the number of people we have encountered who have talked with a few AA members or attended an open AA meeting where they talked to a few willing informants and left such experiences feeling as if they understood AA. As long-time researchers of AA, it is our experience that the person most willing to speak first on behalf of AA is, by definition, the least qualified to do so. Wilson addressed this question of the voice of AA by first depicting two archetypal AA roles—the "bleeding deacon" and the "AA show-off"—who are most likely to assert themselves as the embodiment and voice of AA (Alcoholics Anonymous, 1957, p. 122, 133). Wilson went on to suggest that most AA members matured out of this role to become the "elder statesmen" whose humility, wisdom, patience, and example qualified them as the "true voice of Alcoholics Anonymous" (Alcoholics Anonymous, 1957, p. 122). The best access we have to this voice is in AA's core literature through which Wilson attempted to express the collective experience of those who shared this "kinship of common suffering" and who had reaped the promises of recovery (Alcoholics Anonymous, 1957, p. 59). The clearest definition of Twelve Step philosophy can be found in AA's basic texts and the other writings of AA co-founder Bill Wilson, particularly his articles in the *AA Grapevine*.

Focusing on AA (as opposed to other Twelve Step groups) and the writings of Bill Wilson to answer the questions we have posed is warranted for several reasons:

- AA is the first and longest surviving Twelve Step program.
- AA is the largest (in total membership—1.9 million members—and number of registered groups—more than 114,000) and most geographically dispersed (more than 180 countries) Twelve Step program.
- AA's Steps and Traditions constitute the program from which all other Twelve Step programs have been adapted.
- Bill Wilson is the primary author of A.A.'s basic texts and was the primary interpreter of AA history, philosophy, and practices during AA's seminal years of development.
- The AA literature authored by Bill Wilson, perhaps more than the literature of any other recovery support group, exerted a significant and continuing influence on the practice of addiction treatment, particularly in the United States.

Bill Wilson, the intellectual engineer of AA and by derivation, other Twelve Step recovery programs, died in 1971. He did not live to witness and offer commentary on the more than 60 adjunctive and alternative addiction recovery mutual aid societies that have risen since his passing (see White, 2010 for a chronology of such groups). He did not live to share his thoughts on the rapidly growing varieties of spiritual, religious, and secular approaches to addiction recovery within and outside of AA.

representative websites, see http://www.orange-papers.org/; http://www.aadeprogramming.org/index_frames.html).

However, his early writings provide important clues to his appreciation and even celebration of such diverse recovery experiences. It is hoped that this essay will bring Wilson's own words to a new audience of readers who are not aware of his reflections on what continue to be contentious issues within and outside of AA. Wilson's words are offered here with a minimum of accompanying commentary. They speak for themselves on several pervasive themes: respect for the varieties of recovery experience within AA, respect for the varieties of recovery that can be achieved outside the fellowship of AA, an unending search for ways to widen the doorways of entry into recovery and respect for AA's critics.

**Varieties of AA Experience**

AA's Core Values: If one reads through AA's basic texts (*Alcoholics Anonymous*, *Twelve Steps and Twelve Traditions,* and *Alcoholics Anonymous Comes of Age*) and the other voluminous writings of AA co-founder Bill Wilson, even the casual reader will note several core values that permeate these works. These core values guide AA's internal and external relationships as well as AA's view of alternative approaches to alcoholism recovery. The most frequently referenced of these values in AA literature are honesty, modesty, humility, humor, tolerance, patience, unselfishness, kindliness, love, and service.

The values of tolerance and modesty form a particularly important foundation to the writings cited in this paper.

> *Most of us sense that real tolerance of other people's shortcomings and viewpoints and a respect for their opinions are attitudes which make us more useful to others.* (*Alcoholics Anonymous*, 1939, p. 30)

> *Personal glorification, overweening pride, consuming ambition, exhibitionism, intolerant smugness, money or power madness, refusal to admit mistakes and learn from them, self-satisfaction, lazy complacency—these and many more are the garden variety ills which so often beset movements as well as individuals…. Let us never say, "It can't happen here."* (Wilson, 1945/1988a, p. 4)

AA's own modesty is evident in Bill Wilson's repeated declarations that the core philosophy of AA is not new.

> *At the very outset we should like it made ever so clear that AA is a synthetic concept—a synthetic gadget, as it were, drawing upon the resources of medicine, psychiatry, religion and our own experience of drinking and recovery. You will search in vain for a single new fundamental.* (Wilson, 1944, p 1805)

> *Does Alcoholics Anonymous contain any new principle? Strictly speaking it does not. AA merely relates the alcoholic to time tested truths in a brand new way.* (Wilson, 1950)

Such modesty is also evident in Wilson's repeated denials that AA is the only way to solve alcohol problems.

> *AA has no monopoly on reviving alcoholics.* (Wilson, 1944/1988, p.98)

> *The average member of Alcoholics Anonymous does not suppose we have a cure-all.* (Wilson, 1945b, p. 239)

> *In all probability, we shall never be able to touch more than a fair fraction of the alcohol problem in all its ramifications. Upon therapy for the alcoholic himself, we surely have no monopoly.* (*Alcoholics Anonymous*, 1955, p. ix)

> *In no circumstances should members feel that Alcoholics Anonymous is the know-*

*all anddo-all of alcoholism.* (Wilson, 1965/1988, p. 332)

> *Then, too, it would be a product of false pride to believe that Alcoholics Anonymous is a cure-all, even for alcoholism.* (Wilson, 1963/1988, p. 346)
>
> *When you consider the ramifications of this disease, we have just scratched the surface. I think we should humbly remember this.* (Wilson, 1969, p. 9)

AA's elevation of humility as an aspirational value is perhaps best exemplified through its rejection of absolutes—a position that led to its early split from the Oxford Group—and through what in AA folklore became reified as *Rule No. 62*: "Don't take yourself too damned seriously" (Kurtz, 1979; Alcoholics Anonymous, 1957, p. 104).

On Dogma and Coercion: Bill Wilson feared that dogma—seeing AA as the only way to recover or reducing AA to a concretized set of beliefs or rules—could injure AA as such dogma had injured AA's predecessors.

> *It is an historical fact that practically all groupings of men and women tend to become more dogmatic; their beliefs and practices harden and sometimes freeze. This is a natural and almost inevitable process…. But dogma also has its liabilities. Simply because we have convictions that work well for us, it becomes very easy to assume that we have all the truth….This isn't good dogma; it's very bad dogma. It could be especially destructive for us of AA to indulge in this sort of thing*. (Wilson, 1965/1988, p. 333)

The degree of Wilson's fear about the harmful effects of imposing a set of beliefs on new AA members is indicated by the number of times he returned to this subject. The excerpts below, spanning nearly 20 years, are representative of his expressed concerns.

> *Most strongly we point out that adherence to these principles* [the Steps] *is not a condition of AA membership. Any alcoholic who admits he has a problem is an AA member regardless of how much he disagrees with the program. Based upon our experience, the whole program is a suggestion only.* (Wilson, 1944, p. 1807)
>
> *It is a tradition among us that the individual has the unlimited right to his own opinion on any subject under the sun. He is compelled to agree with no one; if he likes, he can disagree with everyone.* (Wilson, 1944/1988, p. 98)
>
> *…the Twelve Steps of our AA program are not crammed down anybody's throat. They are not sustained by any human authority. Yet we powerfully unite around them because the truth they contain has saved our lives, has opened the door to a new world.* (Wilson, 1945/1988b, p. 8)
>
> *This clearly implies that an alcoholic is a member if <u>he</u> says so; that we can't deny him membership; that we can't demand from him a cent; that we can't force our beliefs and practices upon him; that he may flout everything we stand for and still be a member. In fact, our Tradition carries the principle of independence for the individual to such an apparently fantastic length that, so long as there is the slightest interest in sobriety, the most unmoral, the most antisocial, the most critical alcoholic may gather about him a few kindred spirits and announce to us that a new Alcoholics Anonymous Group has been formed. Anti-God, anti-medicine, anti-our recovery program, even anti-each other—these rampant individuals are*

*still an AA group if <u>they think so</u>.* (Wilson, 1946/1988a, p. 33)

*Perhaps there is no society on earth more solicitous of personal welfare, more careful to grant the individual the greatest possible liberty of belief and action. Alcoholics Anonymous has no "musts"….compliance or noncompliance with any AA principle is a matter of conscience of the individual….* (Wilson, 1947/1988b, p. 76)

*We realize that he is altogether too weak and confused to jump hurdles. If we raise obstacles, he might stay away and perish. He might be denied his priceless opportunity.* (Wilson, 1948/1988, p. 79)

*Alcoholics Anonymous does not demand that you believe in anything. All of its Twelve Steps are but suggestions.* (Alcoholics Anonymous, 1952, p. 26)

*Neither does AA exert the slightest religious authority over its members. No one is compelled to meet membership conditions. No one is obliged to pay anything. Therefore we have no system for authority, spiritual or temporal….* (Wilson, 1960)

*So this is the substance of the AA party line as I happen to see it. But please be assured you don't necessarily have to see it the same way. Plenty of people differ with me, and yet remain sober…. AA's orthodoxy, if it can be called that, is merely what the majority experience suggests. You can still take your pick!* (Wilson, 1962/1988b, p. 274)

<u>Varieties of AA Experience</u>: Wilson often remarked that, beyond the "suggestions" set forth in AA's Twelve Steps, there is no ONE true brand of AA. Wilson chastised those AA members who conveyed the message, "Folks, *listen to us*. *We* have the only true brand of AA—and you'd better get it!" (Wilson, 1961/1988b, p. 252). He illustrated the futility such an attitude in the following 1946 reflection on AA's early history.

> *Two or three years ago the Central Office* [of AA] *asked the groups to list their membership rules and send them in. After they arrived we set them all down. They took a great many sheets of paper. A little reflection upon those rules brought us to an astonishing conclusion. If all these edicts had been in force everywhere at once, it would have been practically impossible for any alcoholic to have ever joined Alcoholics Anonymous. About nine-tenths of our oldest and best members could never have gotten by!* (Wilson, 1946/1988, p. 37)

That understanding was subsequently codified in AA's Third Tradition, "The only requirement for A.A. membership is a desire to stop drinking", which stated unequivocally that "any alcoholic is a member of our Society when he says so" (Alcoholics Anonymous, 1952/1981, p. 139, 145)

Wilson further illustrated his respect for the varieties of recovery experience within AA by contrasting styles of change within AA—from his own experience of sudden transformational change to the more typical incremental change experienced by most AA members.

> *There is a very natural tendency to set apart those experiences of awakenings which happen to be sudden, spectacular, or vision-producing…. It now seems clear that the only special feature of my experience was its electric suddenness and the overwhelming and immediate conviction that it carried to me…. I am sure that my own experience was not in the least different from that received by every*

*AA member who has strenuously practiced our recovery program.* (Wilson, 1962/1988a, p. 275)

Wilson's earliest writings did not address the subject of styles of AA participation, but as early as 1945, he did note people who were recovering in AA without access to AA meetings.

*It was discovered several years ago that the "A.A." job could be done solely through correspondence and our literature.* (Wilson, 1945b, p. 241)

When he testified before a Senate Subcommittee in 1969, Wilson also alluded to the number of people who had achieved sobriety in AA, disengaged from active AA participation, and sustained their recovery without AA involvement.

*Besides the 285,000* [AA's active membership in 1969] *there are hundreds of thousands—maybe 200,000, for all we know, 300,000 recovered AA's on the sidelines who do not get caught up in the active statistics, people who have remained for the greater part sober, who are carrying AA attitudes and practices and philosophies into the community life.* (Wilson, 1969, p. 3)

**Varieties of Recovery Outside of AA**

The question of alternative pathways of recovery came up early in the history of AA. The September 1944 issue of the *AA Grapevine* included an article by noted author Philip Wylie, who described his solo recovery from alcoholism (without the help of AA). Anticipating some potential resistance among AA readers, the *Grapevine* editor asked Bill Wilson to offer comment on Wylie's story. Bill declared that Wylie's article should "endear" Wylie to every AA member.

*No AA should be disturbed if he cannot fully agree with all of Mr. Wiley's truly stimulating discourse. Rather shall we reflect that the roads to recovery are many; that any story or theory of recovery from one who has trod the highway is bound to contain much truth.* (Wilson, 1944/1988, p. 98)

Bill Wilson responded similarly to the question of whether people could recover from alcoholism through professional help alone. Here is an excerpt from his address to the New York State Medical Society on Alcoholism in 1958:

*Your President and other pioneers in and outside your Society have been achieving notable results for a long time, many of their patients having made good recoveries without any A.A. at all. It should be noted that some of the recovery methods employed outside A.A. are quite in contradiction to AA principles and practices. Nevertheless, we of AA ought to applaud the fact that certain of these efforts are meeting with increasing success.* (Wilson, 1958)

Two years later, Bill Wilson was asked whether the principles of Recovery, Inc.—a self-help mental health recovery program founded in 1937 by Dr. Abraham A. Low—might be used to help alcoholics. Wilson's response illustrates AA's values of modesty and tolerance even in judging ideas, people, and programs counter to AA central tenets.

*I have always looked with great sympathy upon Recovery, Inc. The founder of that movement was a psychiatrist. In actuality, Recovery Inc. is very much of a heresy to AA. But it's the kind of heresy that often seems to work. Those good people operate on the basis that through a program of discipline and constant exertion of the will, their several compulsions and hexes can be directly attacked and eliminated…. In*

> *many cases their results have been extraordinary…. Altogether I have the highest opinion of that outfit.* (Wilson, 1960)

The Question of Secular Recovery: Bill Wilson wrestled for many years with the question of recovery from alcoholism that did not apparently involve a spiritual dimension. He first noted the numbers of atheists and agnostics who had recovered in AA.

> *Alcoholics Anonymous is not a religious organization; there is no dogma. The one theological proposition is a "power greater than one's self." Even this concept is forced on no one. The newcomer merely immerses himself in our society and tries the program as best he can. Left alone, he will surely report the gradual onset of a transforming experience, call it what he may.* (Wilson, 1949/1994, pp. 261-262)

Bill Wilson thought that the potential for successful non-spiritual recovery from alcoholism depended primarily on the severity of alcoholism. He believed that non-spiritual approaches could work for those with less severe alcohol problems but that a spiritual awakening might well be necessary for the most severe forms of alcoholism.

> *Whether such a person can quit upon a non-spiritual basis depends upon the extent to which he has already lost the power to choose whether he will drink or not.* (*Alcoholics Anonymous*, 1939, p. 45)

> *…it doesn't matter too much how the transforming spiritual experience is brought about so long as one gets one that works for him. Somehow the alcoholic must get enough objectivity about himself to abate his fears and collapse his false pride. If he can do all that through his intellect, and thereafter support his life structure upon a "transcendent symbol," more power to him! ...the more intellectual techniques do work sometimes, reaching those who might never take the stronger dose.* (Wilson, 1944/1988, p. 98)

Religion and Recovery: Bill Wilson's respect for the varieties of AA experience is further reflected in his comments on the role of religion in recovery.

> *We think it no concern of ours what religious bodies our members identify themselves with as individuals. This should be an entirely personal affair which each one decides for himself in the light of past associations, or his present choice. Not all of us have joined religious bodies, but most of us favor such memberships.* (*Alcoholics Anonymous*, 1939, p. 39)

> *If he thinks he can do the job in some other way, or prefers some other spiritual approach, encourage him to follow his own conscience. We have no monopoly on God; we merely have an approach that worked with us.* (*Alcoholics Anonymous*, 1939, p. 108)

As Wilson drafted what became the book, *Alcoholics Anonymous*, he faced a dilemma. He knew that many alcoholics had a distinct aversion to anything smacking of God and religion, yet he had to convey the role spiritual experience had played in the recoveries of AA's first members. As work on the book continued, a great tension rose between conservative, liberal, and radical viewpoints on the role of religion in the AA program of recovery. The conservatives wanted an explicitly Christianized framework of recovery, the liberals were okay with "God" but rejected any attempt to inject religious doctrine into the AA program, and the radicals (atheists and agnostics) wanted no reference to God. The challenge for codifying AA's program was crafting language that reflected this diversity of

recovery experience (Alcoholics Anonymous, 1957).

Wilson's way out of this dilemma was through four propositions. First, he defined the problem of alcoholism as a problem of power ("Lack of power, that was our dilemma"; *Alcoholics Anonymous*, 1939, p. 57). Second, he defined the essential task of recovery as the acquisition of power ("We had to find a power by which we could live…; *Alcoholics Anonymous*, 1939, p.57). Third, that power had to transcend the assertion of personal will ("…it had to be a Power greater than ourselves"; *Alcoholics Anonymous*, 1939, p. 57). Fourth, that Power was defined broadly ("To us, the Realm of the Spirit is broad, roomy, all inclusive…; *Alcoholics Anonymous*, 1939, p. 59) and personally ("Experience has taught us that these are…matters for each individual to settle for himself"; *Alcoholics Anonymous*, 1939, p. 62). Conservatives, liberals, and radicals are still embraced within the fellowship of AA, and one can get a quite different view of AA depending on which member is describing AA through the lens of his personal experience. Wilson was in a unique vantage point to try to depict the diversity and totality of AA recovery experience—dimensions that can be missed by both AA advocates and AA critics.

Medication and Recovery: As early as 1945, Bill Wilson warned AA members of the dangers of drugs other than alcohol.

> *Morphine, codeine, chloral hydrate, Luminal, Seconal, Nebutal, amytal, these and kindred drugs have killed many alcoholics. And I once nearly killed myself with chloral hydrate.* (Wilson, 1945/1988c, p. 103)

Yet Wilson remained open throughout his life to the potential role of pharmacological adjuncts in recovery from alcoholism. We know that he used sedatives for an undetermined length of time during his ongoing treatment for depression between the mid-1940s and 1953, and that he personally used and publicly promoted LSD and Vitamin B-3 as adjuncts in the treatment of alcoholism during the late 1950s and early 1960s—before LSD had been christened a "drug of abuse"—at a time LSD was being recommended by prominent psychiatrists as a potential breakthrough treatment for alcoholism. Wilson hoped these aids might help those who failed to get the AA program (Kurtz, 1979, 1999; Wilson, 1965a).

Wilson's continued openness to medications in the role of recovery is further illustrated by a story told by Dr. Vincent Dole, co-developer of methadone maintenance and non-alcoholic trustee of AA. Dole recounts that in one of his last conversations with Bill Wilson, Wilson had asked Dole if there might be an analogue of methadone that could be used in the treatment of alcoholism and encouraged Dole to undertake research to discover it (Dole, 1991).

Moderation as a Solution to Alcohol Problems: Moderation had not worked for early AA members, but they made no effort to deny that option to others. In fact, they took quite the opposite position. AA's (Wilson-authored) basic text suggested moderation as an option for some problem drinkers.

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason-ill health, falling in love, change of environment, or the warning of a doctor-becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention.* (*Alcoholics Anonymous*, 1939, p. 31)
>
> *If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like*

*other people!* (*Alcoholics Anonymous,* 1939, p. 42)

Bill Wilson and the broader literature of AA make no claim that their experience constitutes a universal truth applicable to the broader universe of all alcohol problems. By distinguishing themselves ("real alcoholics") from problem drinkers, early AA members defined their own recoveries in terms of abstinence because that is what had been successful in their experience.

**Tolerance and Open-mindedness**

We have illustrated the respect Bill Wilson expressed toward the varieties of methods and styles of recovering from alcoholism and resolving other forms of alcohol-related problems. Wilson's tolerance and open-mindedness are further illustrated in his stand toward AA's cooperation with service professionals and scientists, his continual efforts to widen the doorways of entry into recovery, his openness to change and his response to AA critics.

On Cooperation with Professionals and Scientists: Wilson brought personal experience to the question of the role of professional treatment in alcoholism recovery, and Wilson's treatise on the early history of AA is replete with expressions of gratitude to the roles non-alcoholic professionals and other non-alcoholic friends of AA played in the history of the fellowship (Alcoholics Anonymous, 1957). He had been treated multiple times before his successful recovery, and he often acknowledged the role of his physician, Dr. William Silkworth, in his own recovery process and in the birth of AA—going so far as to refer to Silkworth as a "founder of A.A." (*Alcoholics Anonymous*, 1957, p. 13). Wilson also was treated by two psychiatrists for the depression that lingered years into his recovery. Also of interest is the fact that Wilson came very close to accepting employment as a lay alcoholism therapist at Charles Towns Hospital in New York City, and that he did later briefly serve on the board of an alcoholism rehabilitation facility (High Watch) (White, 1998). These experiences and the larger body of AA experience with expanding alcoholism treatment resources shaped his views of the role of treatment in recovery and the role AA members might play working in the larger alcoholism treatment field.

> *…many* [AA members] *were called and many chosen since that day to go into related fields* [helping alcoholics] *which has now got to be so large in their promise that we of Alcoholics Anonymous are getting down to our right size and we are only now realizing that we are only a small part of a great big picture. We are realizing again, afresh, that without our friends, not only could we have not existed in the first place but we could not have grown.* (Wilson, 1956)

> *It used to be the fashion among some of us in A.A. to decry psychiatry, even medical aid of any description, save that barely needed for sobering up. We pointed to the failures of psychiatry and religion. We were apt to thump our chests and exclaim, "Look at us. We can do it, but they can't." It is therefore with great relief that I can report this to be a vanishing attitude. Thoughtful AA members everywhere realize that psychiatrists and physicians helped to bring our Society into being in the first place and have held up our hands ever since…. So let's bring to this floor the total resources that can be brought to bear on this problem…Let us think of unity among all those who work in the field…Let us stand together in the spirit of service.* (Wilson, 1958)

> *We clearly see that by pooling our resources we can do together what could never be accomplished in separation; or in short-sighted criticism and in competition.* (Wilson, 1958)

> *We* [AA members] *should very seriously ask ourselves how many alcoholics have gone on drinking because we have failed to cooperate in good spirit with these many* [alcoholism treatment] *agencies—whether they be good, bad or indifferent. No alcoholic should go mad or die merely because he did not come straight to A.A. at the beginning.* (Wilson, 1965b)

> *AA does not sponsor projects in other fields. But if these projects are constructive and non-controversial in character, AA members are free to engage in them without criticism if they act as individuals only, and are careful of the AA name.* (Wilson, 1947/1988a, p. 46)

Wilson's views on cooperation with professionals extended to the scientific community.

> *Please know that we* [AA] *hold ourselves ready for scientific investigation; that we fully realize that we are but a small part of the total effort going on in this broad field and so wish to aid where we can.* (Wilson, 1950)

> *Today, the vast majority of us* [AA members] *welcome any new light that be thrown on the alcoholic's mysterious and baffling malady. We don't care too much whether new and valuable knowledge issues from a test tube, a psychiatrist's couch, or from revealing social studies…. More and more we regard all who labor in the total field of alcoholism as our companions on a march from darkness to light. We see that we can accomplish together what we could never accomplish in separation and rivalry.* (Wilson, 1958/1988, p. 185)

Wilson's Obsession: The Unrecovering Alcoholic: Bill Wilson manifested something of an obsession throughout his years of recovery. While others were celebrating AA's near miraculous survival and growth, Wilson continued to concentrate his attention on the still suffering alcoholic—particularly those who came to AA but failed to get the program and achieve sustained physical and emotional sobriety.

> *Our first concern would be with those sufferers that we are still unable to reach…. Some cannot be reached because they are not hurt enough, others because they are hurt too much.* (Wilson, 1965/1988, p. 331)

Wilson's concerns with the still suffering alcoholic were the source of his later interest in LSD and Vitamin B-3 as potential adjuncts in recovery from alcoholism (see Kurtz, 1999 for a full discussion).

Openness to Change: Throughout his years of recovery, Bill Wilson maintained an openness to change for himself and for AA. His consciously cultivated humility undergirded Wilson's ability to keep his current ideas open to revision pending new knowledge and experience.

> *The process* [trial and error] *still goes on and we hope it never stops. Should we ever harden too much, the letter might crush the spirit. We could victimize ourselves by petty rules and prohibitions; we could imagine that we had said the last word. We might even be asking alcoholics to accept our rigid ideas or stay away. May we never stifle progress like that!* (Wilson, 1946/1988b, p. 20)

> *We have to grow or else deteriorate. For us, the "status quo" can only be for today, never for tomorrow. Change we must; we cannot stand still.* (Wilson, 1961/1988a, p. 321)

> *Let us never be a closed corporation.* (Wilson, 1963/1988, p. 346)
>
> *Let us never fear needed change. Once a need becomes clearly apparent in an individual, a group, or in AA as a whole, it has long since been found that we cannot stand still and look the other way.* (Wilson, 1965/1988, p. 334)
>
> *Let us always remember that any society of men and women that cannot freely correct its own faults must surely fall into decay if not collapse. Such is the universal penalty for the failure to go on growing. Just as each AA must continue to take his moral inventory and act upon it, so must our whole Society do if we are to survive and if we are to serve usefully and well.* (*Alcoholics Anonymous*, 1957, p. 231)
>
> *Pioneering in A.A. of course has not stopped. I hope it never will.* (Alcoholics Anonymous, 1957, p. 80)

Response to Critics: AA's core values were most tested in the face of criticism. In 1959, Bill Wilson reported to AA's General Service Conference:

> *As a society, we have seen no attacks, nor have we been attacked. We have made no aggressions on the world outside and they have not trespassed upon us; they have befriended us.* (Wilson, 1959)

For the most part, AA escaped public criticism in its first 25 years of existence, but such criticism began in the 1960s and evolved into a fully organized Twelve Step backlash movement in the 1980s and 1990s. When AA members asked Bill Wilson to respond to early public criticism, he penned an article in the April 1963 *AA Grapevine* entitled, "Our Critics Can be Our Benefactors." In that article, Wilson highlighted excerpts from earlier writings that called upon AA to not respond to such criticism publicly, lest AA get caught up in public controversy that diverted the fellowship from its central mission. Instead, Wilson urged members to use such criticism as an opportunity for self-inventory and self-improvement, going so far as to suggest, "*If a given criticism of AA is partly or wholly justified, it may be well to acknowledge this privately to the critics, together with our thanks"* (Wilson, 1963/1988, p. 347).

**Summary**

This short essay has used excerpts from the writings of Bill Wilson to illustrate AA's understanding of its own limitations, recognition of diverse recovery experience within AA, tolerance toward alternative pathways and styles of recovery, openness to collaborate with service professionals and scientists in the alcoholism field, and Wilson's personal hope that AA would remain an open, evolving society forever focused on service to and recovery for the still suffering alcoholic.

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# Selected Papers of William L. White

**www.williamwhitepapers.com**

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## Practicing Physicians Can Combat Addiction and Promote Lifelong Recovery

**Robert DuPont, M.D. and William L. White, M.A.**

Many practicing physicians think of alcohol and other drug (AOD) dependence as hopeless, at least in part because of past frustrations in dealing with these patients. The good news is that today, there is growing evidence of long-term recovery from addiction and the significant role physicians can play in helping initiate and sustain such recoveries. The authors have each worked in the addiction treatment arena for more than 40 years. We offer the following seven prescriptions on how physicians can help their patients resolve AOD-related problems. In all of medicine, there are few outcomes as dramatic and as gratifying to both physicians and patients as recovery from addiction.

1. Routinely Screen: Ask all of your patients about their use of alcohol and other drugs. Start with these two questions: 1) In the past 12 months, have you consumed more than 5 drinks in a day, and 2) In the past 12 months, have you used any illegal drugs or used any prescription drugs in ways not intended by your physician? A “yes” to either question requires detailed follow-up. A “no” to both deserves a pat on the back! When a patient’s alcohol or drug use poses a risk for problem development, the physician can help the patient set goals related to the limitation or cessation of AOD use and schedule a follow-up visit to monitor progress toward these goals. Brief encouragement by physicians with the expectation of positive progress has been shown to be a significant patient motivator. Physicians can educate their patient about factors that are associated with increased risk for development of severe and prolonged AOD problems, e.g., a family history of AOD problems, early age of onset of AOD use, unusually high AOD tolerance, traumatic stress, or a co-occurring psychiatric illness.

2) Link to Specialized Help: For those patients who are not able to stop their alcohol and/or drug use once problems have been identified, the physician can explore with the patient options for specialized assistance. These options could include a combination of participation in addiction recovery support groups such as Alcoholics Anonymous or Narcotics Anonymous, referral to a specialized addiction treatment program, and prescribing medication (e.g., naltrexone) that can reduce cravings and bolster early efforts at sobriety. Refer family members to Al Anon, the 12-step program for those who care about people addicted to alcohol and other drugs. This linkage process is most successful when physicians or their assistants can assertively connect

the patient to a particular group, program, or person for additional help.

3) Support and Monitor: For patients with Substance Use Disorders (SUDs), provide encouragement, your expectation of positive outcomes from their efforts, and then regularly monitor their progress toward sustained abstinence from alcohol and drug use and their active participation in addiction treatment and recovery mutual aid meetings. Ongoing monitoring and support (with scheduled follow-up appointments) bolster motivation for the recovery process, provide opportunities to educate the patient about the physical and emotional process of recovery, and if and when needed, provide opportunities for early re-intervention.

4) Demonstrate Knowledge of Recovery Process: Review some of the key literature of recovery mutual aid societies and attend a few open 12-step meetings so that you can credibly and convincingly convey knowledge and support of these programs to your patients. For patients who are in one of the 12-step fellowships, ask about issues known to enhance long-term recovery outcomes, e.g., have a home group, frequently attend meetings, regularly read program literature, have and use a sponsor, and sponsor newcomers to the program. Encourage and support patients' efforts, praise their progress, and offer guidance on obstacles they encounter in the recovery process. For patients who object to 12-step programs, a regularly updated listing of all of the secular and religious alternatives to 12-step programs can be located at www.facesandvoicesofrecovery.org.

5) Educate Patients about Recovery: Use the word "recovery" in talking with your patients with SUDs. Convey to them that recovery is more than abstinence from alcohol and other drug use. Recovery includes improving one's overall physical and emotional health and living a better, fuller, and more honest life. Encourage your patients with SUDs to learn from their struggles and share their experience, strength, and hope with others who might benefit from their experience.

6) Conduct Recovery Checkups: For patients who are in long-term stable recovery, integrate questions related to their recovery maintenance activities into annual exams. Continue to offer praise and encouragement for their recovery support activities and note any emotional crises (death, divorce, job loss, retirement, onset of other illnesses) that could pose a threat to recovery stability. Be especially vigilant about the prescription of controlled substances to patients in recovery because these medicines can precipitate a relapse.

7) Capitalize on Crises: For patients who continue to struggle with severe and prolonged substance use disorders, continue to treat their AOD-related medical disorders while consistently communicating the connection between these disorders and their AOD use. Capitalize on medical crises as motivational opportunities for recovery initiation. The co-founders of Alcoholics Anonymous (one a physician) experienced multiple detoxifications and failed sobriety experiments before they each faced a crisis that led to stable, lifelong recovery and to their work helping thousands—and now millions—of others suffering from this same problem.

Modern science has confirmed the powerful, positive role physicians can play in the initiation and maintenance of long-term recovery from substance use disorders. The seven steps outlined in this article are key steps through which that potential can be achieved.

A bonus for the physician: there are no more grateful or more rewarding patients than those in addiction recovery. Playing a central role in patients' recovery from addiction is one of the most inspiring and fulfilling experiences a physician can have. We know because we see this modern miracle in our own practices every day.

**About the Authors**: Dr. Robert DuPont is the founding Director of the National Institute on Drug Abuse, President of the Institute for Behavior and Health Inc., and the author of *The Selfish Brain—Learning from Addiction*. 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*.



# Selected Papers of William L. White

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## Celebrating the Varieties of Recovery Experience

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In 2001, recovery advocates from around the country assembled in St. Paul, Minnesota, to launch a new recovery advocacy movement. There were many ideas competing for prominence at this first recovery summit, but two achieved rapid consensus and have since become key philosophical tenets of the movement:

1) addiction recovery is a reality in the lives of millions of individuals and families, and
2) there are many pathways of long-term recovery, and all are cause for celebration.

Nowhere are these ideas more clearly manifested than in local and national Recovery Month activities.

This month, more than 100,000 individuals in recovery and their families, friends, and allies will participate in public recovery celebration events. Our faces and voices will offer living proof of long-term addiction recovery and will illustrate more than any scientific study the growing varieties of recovery experience. The sights and sounds of these events will convey the rainbow of colors, classes, cultures, and languages that make up the contemporary history of addiction recovery.

This month, recovering people will stand together—transcending all manner of differences in our addiction histories; our distinctive religious, spiritual, and secular pathways of recovery; and our diverse life circumstances. We will stand as a people with a shared past and a shared destiny declaring to all: "If we can heal, you can heal. If we and our families can heal, then neighborhoods and communities can heal. And if communities can heal, then the wounds of our country and the world can also heal."

William White
Author, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*



# Selected Papers of William L. White

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## Inside Addiction
## An Interview with William White

**William L. White**
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**Inside Addiction:** What got you interested in the New Recovery Movement?

**Bill White:** A blend of personal activism and my fascination with the history of addiction recovery. In the late 1990s, I was writing about the restigmatization, demedicalization, and recriminalization of addiction throughout the 1980s and 1990s. As a recovery historian, I knew that these conditions often sparked grassroots advocacy movements led by recovering people and their families and allies, but I failed to predict just how quickly that movement would emerge. By 2000, that movement was already taking shape, and in 2001, recovery advocates from around the country met in St. Paul, Minnesota to cast the future of the movement. We had no idea just how historic that meeting would be.

This past September, more than 100,000 recovering people and their families participated in some 200 Recovery Month activities. The recovery advocacy movement is birthing hundreds of new recovery community organizations, increasing the long-term recovery orientation of addiction treatment, wrapping treatment in a more extensive menu of sustained recovery support services, and radically altering how this country views recovery. And it is rapidly spreading to Europe, Asia, and Africa. What this movement has achieved in the past decade is beyond anything imagined by those of us who met in St. Paul. It has been a privilege to witness and document the cultural and political awakening of individuals and families in recovery.

**Inside Addiction:** What is a recovery coach?

**Bill White:** Historically, we have had two types of recovery support roles. There are addiction and allied health professionals who screen, evaluate, medically and psychologically treat, and then discharge individuals and families affected by addiction. And there are the sponsors/guides who provide temporary or prolonged peer-based guidance within particular recovery mutual aid societies. The recovery coach

(RC) is a new role that stands between the professional and the sponsor. RCs differ from the professional in that they are experientially credentialed rather than professionally credentialed, and they provide no medical or counseling services. RCs differ from the sponsor, in part, because they work with people across multiple pathways of recovery, not just within a single recovery fellowship. RCs provide outreach to people in need of recovery, assertively link people to professional treatment and to communities of recovery, and provide long-term, stage-appropriate recovery education and support.

**Inside Addiction:** What is your personal vision of the recovery coach role?

**Bill White:** My personal vision is that the RC will provide the human connecting tissue within an increasingly fragmented and impersonal professional service system, and will serve, for some, as an alternative to that system. I see the RC as the person who has your back through the process of pre-recovery engagement, recovery initiation, the transition to stable recovery maintenance, and the achievement of enhanced quality of personal/family life in long-term recovery.

**Inside Addiction:** How do you envision recovery coaches being utilized?

**Bill White:** RCs are now being employed within addiction treatment organizations (particularly in the areas of outreach and post-treatment continuing care) and child welfare and criminal justice initiatives. They are working in paid and volunteer roles within recovery community organizations, and they are working in independent roles within a new form of private practice. Everyone else in the system is acting like recovery is a hundred yard dash; the RC is saying, “Pace yourself, this is a marathon!”

**Inside Addiction:** How does this role fit into Health Care Reform?

**Bill White:** I think some version of the RC role will be integrated into the health care reform process as a reimbursable service. We are already seeing some managed care companies reimburse these services based on their experience that sustained monitoring and support from a recovery coach reduces the costly recycling of people through multiple episodes of addiction treatment.

**Inside Addiction:** Why did you personally think there was a need for recovery coaches?

**Bill White:** I felt something very important was lost in the addiction treatment field through the diminished recovery representation among addiction professionals (from more than 70% in the early 1970s to about 30% today) and through the over-professionalization of the role of addiction counselor. I saw the recovery coach as a way to retrieve part of that lost value. I think the RC can once again bring to the treatment environment the living proof that long-term recovery is possible and I think it will restore to treatment experiential knowledge of the long-term recovery process and local recovery cultures

**Inside Addiction:** Who becomes and how does someone become a recovery coach?

**Bill White:** Most people serving as RCs draw on their personal or family recovery experiences as a foundation and then go through some specialized training about how this role differs from that of a sponsor or addictions counselor. There are an increasing number of training programs to prepare one for this role.

**Inside Addiction:** New York Recovery Coaches currently represent special populations such as prisons, reentry, LGBT, veterans, seniors, etc. Is this a common trend for recovery coach services?

**Bill White:** It is a natural extension of the RC role as the individuals served get to personally define what “peer” means to

them. For some, the most important ingredient in that is recovery status, but age, gender, sexual orientation, and all manner of other characteristics may be essential to the mutual identification that is such a critical aspect of the recovery support partnership.

**Inside Addiction:** Do you see online and telephone coaching increasing?

**Bill White:** Yes. I don't think we can even begin to fathom how new technologies will be mobilized as instruments of recovery support in the future. The growth of telephone- and internet-based recovery checkups and coaching are already spreading exponentially. This is the new frontier of recovery support and will be particularly well suited for such groups as women, adolescents, status conscious professionals, and people who are homebound or living in areas lacking recovery support resources.

**Inside Addiction:** What do you think is the biggest barrier to people seeking and receiving help?

**Bill White:** When we ask the 90% of people who need but do not seek help why they do not seek assistance, they tell us they 1) don't have a problem, 2) have a problem but can handle it on their own, 3) can't afford treatment, 4) don't believe treatment is effective, or 5) fear the social stigma involved in addiction treatment. Now, we can shake our heads with great condescension and blame individuals for such attitudes, but the fact is we as a country and as a professional field are doing little to alter those perceptions among our most important constituents. Nor are we doing enough to enhance treatment access and quality and post-treatment recovery support.

**Inside Addiction:** How can people help this change?

**Bill White:** These are precisely the kinds of conditions those involved in the new recovery advocacy movement are seeking to change. After all, this is America; if you don't like something, organize and change it. That's precisely what we're trying to do. Anyone who wants to help can contact Faces and Voices of Recovery or their local or state recovery advocacy organization.

**Inside Addiction:** What do people need to know about recovery?

**Bill White**: If by people you mean the public, they need to know what it is (most of the public sees recovery as people who are trying to get their lives together rather than as an achieved and stable status). They need to know that recovery is a vibrant reality in the lives of millions of individuals and families. They need to know that there are many pathways and styles of recovery. And they need to know that participation in professional treatment, peer-based recovery support services, and recovery mutual aid societies are particularly important for people with the most severe and complex substance use disorders. They need to know that recovery flourishes in supportive communities. Communities cannot expect recovery if they do not provide the physical, psychological, and social space for it to grow.

**Inside Addiction:** You have been quite open about your own recovery status. How has this personal experience informed your professional work?

**Bill White:** My recovery drew me to the field and has repeatedly affirmed my commitment to this work, but I try to maintain a reasonably clear boundary between the work I do professionally (the clinical research and consultations and my writing for scientific journals) and what I do as my personal avocation (my advocacy work and my writing on the history of recovery). This work has been more personally and professionally fulfilling than I can adequately express.




# A Primer on Recovery Residences: FAQs

# from the

# National Association of Recovery Residences

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**The National Association of Recovery Residences**
**A Primer on Recovery Residences: FAQs**

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# National Association of Recovery Residences

## A Primer on Recovery Residence in the United States: FAQs

Access this and other papers at www.narronline.com

### Introduction

Recovery residences have spread rapidly in the United States in recent decades. In 2011, the National Association of Recovery Residences (NARR) was founded to promote a recovery-oriented continuum of support for those with substance use disorders by credentialing recovery residences that implement empirically based recovery principles and practice standards. NARR currently represents more than 1,900 recovery residences in the United States. The purpose of this document is to answer some of the most frequently asked questions about recovery residences.

Answers to general questions on recovery residences were prepared by George Braucht, Jason Howell, Dave Sheridan and others on the NARR advocacy committee; answers to questions related to research on recovery residences were answered by an independent expert panel that included Leonard A. Jason, PhD, Director, Center for Community Research, DePaul University; Amy A. Mericle, PhD, Research Scientist, Treatment Research Institute; Douglas L. Polcin, EdD, Senior Scientist, Alcohol Research Group; and William L. White, MA, Senior Research Consultant, Chestnut Health Systems. Assistance in reviewing existing research was also provided by Ronald Harvey, MA, and Bronwyn Hunter, MA, DePaul University, and Fried Wittman, Ph.D., Alcohol Research Group.

Fred Way, Executive Director of the Philadelphia Association of Recovery Residences (PARR), served as liaison between the NARR advocacy committee and the expert panel. At the time this primer was first prepared, the following individuals served on the NARR Board of Directors: Tom Bennett, Texas, Ranch at Dove Tree; Susan Blacksher, California, California Association of Addiction Recovery Resources; Eddie Bryant, Michigan, Michigan Association of Recovery Residences; Michelle Adams Byrne, Texas, Recovery Inn; Susan O Binns, Tennessee, YANA, AHHAP; George Braucht, Georgia, Board of Pardons and Paroles; Lori Criss, Ohio, The Ohio Council of Behavioral Health and Family Services Providers; Chris Edrington, Minnesota, Colorado St. Paul Sober Living; Beth Fisher, Georgia, North Carolina, South Carolina, Hope Homes; Trina Frierson, Tennessee, Tennessee Association of Recovery Residences; Carlos Hardy, Maryland, Maryland Recovery Organization Connecting Communities; Tom Hill, Washington, D.C., Faces and Voices of Recovery; Jason Howell, Texas, Soberhood; Curtiss Kolodney, Connecticut, The Connecticut Community for Addiction Recovery; Ted McAllister, Georgia, Haven Homes; Kevin O'Hare, Michigan, Touchstone Recovery; Dave Sheridan, California, Sober Living Network; Susan Smith, Michigan, Network 180; Nancy Steiner, Florida, Sanctuary; Nathan Lee Tate, Carolina, Recovery Residence Association of the Carolinas; and Fred Way, Pennsylvania, Philadelphia Association of Recovery Residences.

## 1. What is a recovery residence?

"Recovery residence" (RR) is a broad term describing a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems. Many thousands exist in the United States that vary in size, organization, and target population. (The exact number of recovery residences is unknown since many RRs are not regulated by government or independent organizations.) At a minimum, RRs offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence-based, long-term recovery.

Recovery residences are sober living environments, meaning that residents are expected to abstain from alcohol and illegal drug use. Each credentialed recovery residence publishes policies on relapse sanctions and readmission criteria and other rules governing group living. Recovery residences may require abstinence from particular types of medications according to individual policy.

## 2. What is the primary purpose of a recovery residence?

The purpose of a recovery residence is to provide a safe and healthy living environment to initiate and sustain recovery—defined as abstinence from alcohol and other non-prescribed drug use and improvement in one's physical, mental, spiritual, and social wellbeing. Individuals build resources while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community.

## 3. What services do recovery residences provide?

Recovery residences are divided into Levels of Support based on the type as well as the intensity and duration of support that they offer. Services provided span from peer-to-peer recovery support (all recovery residences) to medical and counseling services (recovery residences offering higher levels of support). The NARR Standards define minimum services for each Level of Support, but additional services may be provided at each level. Section 5 of the NARR Standards included in the Appendix details the minimum required service elements for each Level of Support.

## 4. How are recovery residences managed to ensure the safety of the local neighborhood and community?

Recovery residences are guided by the NARR standards that established best practices for maintaining the safety and health of the residents, the local neighborhood, and the larger community. NARR-certified recovery residences meet standards addressing safety from an administrative, operational, property, and good neighbors perspective (see Appendix).

**5. How long have recovery residences existed in the United States?**

Residences with the mission of providing support for recovery from addiction have existed in the United States since the mid-nineteenth century. The first such residence was a room established in 1841 to support members of the newly formed Washingtonian Temperance Society. In 1857, the Washingtonians opened a "home for the fallen" in Boston, which soon closed but was re-opened in 1863 as the Washingtonian Home of Boston, which evolved into one of the premier addiction treatment programs of the nineteenth century. The Washingtonian Homes in Boston and Chicago were part of a larger network of inebriate homes that existed in tandem with religiously sponsored residential inebriate colonies (e.g., Keswick Colony of Mercy), state-sponsored inebriate asylums (e.g., New York State Inebriate Asylum), and private addiction cure institutes (e.g., Keeley Institutes, Gatlin Institutes, Neal Institutes) that thrived until the passage of state and then national prohibition laws (Baumohl & Room, 1987; White, 1998).

The early inebriate homes were replaced in the opening decades of the twentieth century with private hospitals and sanitaria catering to the affluent and local "jag houses" used for detoxification and respite. These gave way in the 1940s and 1950s to the development of recovery-supportive homes, retreats, and farms associated with Alcoholics Anonymous. One factor precipitating this shift included the increased popularity and expansion of Alcoholics Anonymous. A second factor was the emergence of tighter housing markets after World War II in many metropolitan areas, which made it increasingly difficult for individuals with alcohol and drug problems to find sober living environments that supported abstinence (Wittman, Biderman, & Hughes, 1993). In the city of Los Angeles, recovering AA members opened "twelfth step" houses to address the increased need for alcohol- and drug-free living environments. Managers of these houses either mandated or strongly encouraged attendance at AA meetings. By the 1960s, Los Angeles supported several dozen such houses (Wittman, Biderman, & Hughes, 1993). Growth of the houses expanded to other parts of Southern California over subsequent decades and resulted in the creation of the Sober Living Network in 1995. The Sober Living Network currently represents 550 sober living homes in five Southern California counties.

As more state-sponsored alcoholism programs were started in the 1950s, concerns grew about how to sustain personal recovery in the transition from the institution to the community. This birthed new social institutions—the halfway house and the three-quarter-way house—that provided semi-structured residential support designed to aid community re-entry (Cahn, 1969; Raush & Raush, 1968; Rubington, 1970). Many of these programs closed due to a loss of funding as more formal community-based treatment programs increased in the 1960s and 1970s.

A more formal residential model emerged in the late 1940s and early 1950s at Pioneer House and Hazelden that became known as the "Minnesota Model." This model was subsequently medicalized and widely replicated as a residential alcoholism treatment approach throughout the U.S. and Europe (Cook, 1988; Spicer, 1993). In the 1970s, a model of recovery support akin to early Minnesota Model programs developed in California. Christened "social model programs," these programs provided an alternative to more medicalized models of treatment, but many of these programs fell under the sway

of increased professionalism and evolved into more traditional addiction treatment organizations (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Dodd, 1997).

Synanon was founded in 1958 as the first ex-addict-directed therapeutic community in the United States. This residential model of mutual support rapidly expanded in the 1960s and 1970s and was subsequently professionalized as a major addiction treatment modality (De Leon, 2000; Janzen, 2001; White, 1998). In the closing decades of the twentieth century, self-governed, financially self-supported recovery residences rapidly spread in the United States. The largest of these networks of recovery residences is Oxford House that, since its inception in 1975, has grown to 1,521 houses in 45 states with a total resident capacity of more than 12,000 (Oxford House, Inc., 2012).

Recovery residences continued to grow in the opening years of the twenty-first century sparked by both increased need (resulting in part from harsh economic conditions in many cites), the emergence of recovery as an organizing construct for the addictions field, and increased interest in recovery support institutions that could extend the benefits of addiction treatment. The history of recovery residences continues to unfold in the United States.

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## 6. How are recovery residences internally governed and externally regulated?

### 6a. How are recovery residences internally governed at the residence level?

Recovery residences' internal governance varies across NARR's Levels of Support (see Appendix). Forms of governance range from democratically run by the residents to oversight by licensed professionals.

### 6b. How are recovery residences externally regulated?

The regulation of recovery residences vary from state to state, local government to local government, and model to model. In general, states regulate professional services and local governments regulate health and safety standards. Both state and local government regulation must adhere to federal laws and limits, such as the Americans with Disabilities Act and the Fair Housing Act.

### 6c. What role do non-governmental organizations (NGO) play?

A variety of NGOs exist at the local, regional, and national level. NARR exists at the national level and partners with other organizations at the regional level. Many states/regions have NARR affiliates that maintain policies and procedures for their members that meet the NARR Standard. Identify your local affiliate by going to the NARR website: www.narronline.com.

### 6d. Are recovery residences regulated by third party payers?

Some recovery residences accept third party payments (e.g., insurance, HUD, Medicaid, etc.). Third party payers define what is reimbursable and the service duration according to mandated standards of quality and practice. Check with your payer to determine the particular coverage that is offered or contact the specific recovery residences being considered.

## 7. Are there different types of recovery residences?

Yes, there are many different types of recovery residences. Variations are found within and across all four Levels of Support (See Appendix). These levels collectively provide a spectrum of housing to best meet the unique and changing needs of individuals across the stages of long-term recovery. Recovery residences are also designed for

specific/special populations such as language, gender, women with children, age, co-occurring problems, medication status, and prison re-entry.

### 8. How can I find a local recovery residence that best meets my needs?

NARR has defined four levels of recovery support in part to assist individuals looking for facilities that match their needs. Review these levels to determine the most suitable level of support. Then contact your local/regional recovery residence association or speak to individuals active in the local recovery community for recommendations for that particular level of recovery residence. For professionals, an evidence-based placement tool for recovery residence is not available yet. However, ASAM criteria can be used to guide decisions for referral to professionally directed recovery residences.

Government telephone helplines and associated websites provide information on clinical or treatment resources but links to most recovery residences may not be provided. If you recently had a clinical assessment or were in treatment, ask the clinician for several RR recommendations. You can also search for "recovery residences in (your city or state)" on the internet. Additional sources include the telephone book; local professional organizations, faith communities, social service agencies, and resource manuals; and NARR (www.narr-online.com or email: infor@narr-online.com).

### 9. How many recovery residences exist in the United States?

To date, there has been no systematic inventory of RRs in the US. The National Survey of Substance Abuse Treatment Services (N-SSATS) represents the most comprehensive resource on facilities providing substance abuse treatment in the US. Many RRs do not consider themselves treatment facilities, and are not on the master list of organized substance abuse treatment facilities known to the Substance Abuse and Mental Health Services Administration (SAMHSA), which consists primarily of licensed, certified, or otherwise state-approved agencies (US Department of Health and Human Services, 2012). Further, even if RRs were on the master list and participated in the N-SSATS survey, it would be difficult to determine how many of the facilities surveyed identified as RRs because this is not queried as a type of service provided.

Some work to inventory RRs has been conducted by smaller regional and national associations. For example, most recent data provided by Oxford House, Inc. indicates that the current number of Oxford houses (NARR Level 1 residences) is over 1,500, having a total of 11,999 recovery beds (Oxford Grape, 2011). Their online directory lists houses currently operating in 44 states in the US (Oxford House, Inc, 2012). The State of California licenses approximately 900 level III and IV residential facilities the California Association for Addiction and Recovery Resources (CAARR) registers more than 250 sober living residences. (Susan Blacksher, California Association of Addiction Recovery Resources, Personal Communication, September 17, 2012; also see Polcin, Korcha, Bond, & Galloway, 2010). A recovery home (homes comparable to NARR Level 1 and Level 2 residences) mapping initiative conducted in Philadelphia identified 271 homes

with a service capacity for approximately 1,850 residents (Johnson, Martin, Sheahan, Way, & White, 2009).

A critical function of NARR is to serve as a national directory of recovery residences. NARR currently represents 14 associations in 14 states, plus one organization (the Association of Halfway House Alcoholism Programs, AHHAP) with national membership. As of June 2012, NARR represents approximately 1,950 residences (18 level 1, 1,265 level 2, 650 level 3, and 16 level 4) with an estimated total resident capacity of over 25,500 persons in recovery (Fred Way, Personal Communication, July 2012).

More knowledge is needed about how RRs are distributed by state or region and what differences in availability exist between urban, suburban, and rural areas. Regarding the availability of recovery residences by community income, we know access to third-party funding increases the access to RRs, and this increase is expected to be bolstered by the Affordable Care Law in 2014.

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## 10. Where are recovery residences typically located?

As mentioned earlier, RRs can be found in nearly every state in the US. Ideally, houses can be found in residential areas that provide RR residents an opportunity to integrate into the community and provide community members an opportunity to learn about RRs. Unfortunately, RRs often face significant opposition to opening in residential areas and have also been found to be concentrated in poorer residential neighborhoods (Johnson, Martin, Sheahan, & White, 2009).

Fortunately, research conducted to date among community members suggest that negative attitudes toward RRs can be overcome. For example, in interviews with community members living next to and near to Oxford Houses, Jason, Roberts, & Olson (2005) found that community members reported that Oxford House residents blended

well into the neighborhood and made good neighbors. They also found that the majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, they found no evidence of property devaluation in the neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years. Similar results were found by Polcin, Henderson, Trocki, Evan, & Wittman (in press) who interviewed community members about Sober Living Homes (homes comparable to NARR Level 1 and Level 2 residences) in Northern California; however, these researchers did find that size and density of the house appeared to influence neighborhood perceptions and that larger and more densely populated houses may need to more actively manage their relationships with community members.

Standards developed by NARR (see Appendix X) ensure that member houses (regardless of NARR level) abide by all local building and fire safety codes and that they maintain the interior and exterior of the property in a functional, safe, and clean manner that is compatible with the neighborhood. Moreover, these standards provide guidance on "good neighbor" policies to promote positive community involvement in residential neighborhoods.

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**11. Is there a national organization that represents recovery residences in the US?**

The National Association of Recovery Residences (NARR), established in 2011, currently represents approximately 1,500 residences through its local organizational affiliates. NARR advocates for recovery residences and their residents at the national and local levels. NARR members maintain standards for recovery residences of all kinds across four NARR levels of support from Level 1 peer-operated residences to Level 4 residences offering a wide variety of treatment and recovery support services. NARR is also positioned to advocate for recovery residences at the national and state level. At the state and regional level, NARR works in conjunction with affiliated recovery residence provider organizations representing individual providers. Affiliates ensure the NARR Standard is met through training and technical assistance.

Three additional recovery residence organizations exist with a national scope. The oldest is the Association of Halfway House Alcoholism Programs (AHHAP), founded in 1958, and now are affiliated with NARR. AHHAP members include all of the NARR

levels of support. AHHAP residences operate in accordance with social model recovery principles. Oxford House Inc. was established in 1975 and supports Oxford Houses internationally. Oxford Houses are NARR Level 1 residences, with each residence operated solely by the residents in accordance with Oxford House guidelines. Oxford House Inc. supports and promotes its model for peer-operated recovery residences through training, technical assistance, and access to startup financing. They also advocate for recovery housing rights and provide legal support to Oxford Houses involved in disputes with cities and towns over their right to exist. Treatment Communities of America (formerly Therapeutic Communities of America) represents more than 600 residential addiction treatment programs in the United States.

**12. Do recovery residences honor all pathways to recovery or just AA and NA? If so, how do they do that?**

Recovery residences support various abstinence-based pathways to recovery, and each residence focuses on one or more particular pathway. People seeking support for a specific, culturally congruent path to recovery should determine what recovery activities are required before accepting a placement. One key to look for is the respect shown for an individual's choices and an environment wherein residents support each other.

**13. Are residents expected to work and volunteer?**

Working and volunteering are generally considered vital components of recovery (Betty Ford Consensus Panel, 2007; Cloud & Granfield, 2008; White, 2007). Level 1 and 2 residence fees are usually paid by the residents themselves, so they must work onsite and/or offsite to meet their financial obligations. Studies of Oxford House and Sober Living House residents have found that the majority of residents are employed when they enter the residence and that employment outcomes improve over time (Jason, Davis, & Ferrari, 2007; Polcin, Korcha, Bond, & Galloway, 2010). In Level 3 and 4 residences, however, residents' time is more structured and may include numerous recovery activities during the day. In those residences, it may not be reasonable or feasible for residents to also have an outside work or volunteer activity requirement. Still, these residences, as well as Level 1 and 2 residences, may offer job readiness workshops and have relationships with local employers and community organizations to facilitate employment and volunteer involvement among residents.

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## Recovery Home Residents

### 14. How does someone get into a recovery residence?

Entry into a recovery residence usually involves an application/personal interview. Payment of first week's or first month's fees upon acceptance is common. Some residences are closely affiliated with outpatient programs and require concurrent participation in those programs. Other residences draw their residents exclusively from their own addiction treatment or mental health program.

### 15. Are there stages/tiers of participation in recovery residences?

Many residences define levels of recovery progress within the resident community. These levels are often also called phases and correspond with time in the residence, recovery progress as assessed by peers and/or staff, and the degree to which residence behavioral requirements have been met. Each level or phase is typically accompanied by an increase in privileges, greater personal autonomy, exemption from certain requirements of previous phases, and possibly different physical accommodation choices.

Many residences with this type of system often pair later phase residents with new arrivals in a sort of "buddy system." A blackout period is required in the initial phase of some recovery residences. This is a period in which the new resident is required to break communication with the outside world or with their natural supports in order to stabilize and focus on their recovery. Many residences limit the activities for new residents for a length of time after admission. These restrictions might include always being accompanied by a more senior resident when outside the home, limits to contacts with family or friends, and expectations for a higher degree of involvement in recovery support activities. Durations typically range from one week to one month.

**16. What is known about the characteristics of people living within recovery residences?**

The national profile of persons residing in all four levels of recovery homes is not presently available. The founding of NARR may provide a means of gathering that data in the future.

While residential treatment facilities and recovery homes serve all types of individuals, on average, the person is twice as likely to be male, which is consistent with SUD prevalence rates (Jason, Davis, & Ferrari, 2007; SAMHSA, 2011). For individuals undergoing residential treatment, the median age is the early thirties; however age groups from 25 to 49 are almost equally represented. The average age for a resident in a national study of Oxford House residents was 38. (Many recovery residences report that this average iage s decreasing.) Whites represent 60 to 65% of individuals in treatment and recovery homes. African Americans and Hispanics comprise 22% and 12% respectively in residential treatment (SAMHSA, 2011), In the national Oxford House Survey, Whites represented 58% of residents and Blacks and Hispanics represented 34% and 3.5% respectively (Jason, Davis & Ferrari, 2007). Existing data would suggest Hispanics are underrepresented in recovery housing when compared to these treatment statistics.

Of those individuals aged 18 or older in residential treatment, 33% had not completed high school, 42% had a high school degree, and 25% had completed some post-secondary education (SAMHSA, 2011). The average educational level for participants in a recovery residence (Oxford House) study was 12.6 years (Jason, Davis & Ferrari, 2007). Only 11% of those in residential treatment are employed either full-time or part-time; 35% are unemployed; and 54% are not in the labor force. (SAMHSA, 2011). Individuals residing in recovery homes are likely to be employed either full-time (69%) or part-time (14%), or looking for work (unemployed = 12%)(Jason, Davis & Ferrari, 2007).

Both those in residential treatment and in recovery homes are unlikely to be married. Sixty percent of the individuals have never been married, and married individuals make up about 12 to 13% of those in residential treatment (SAMHSA, 2011). For recovery home residents, about half have never been married and only 5% are currently married (Jason, Davis & Ferrari, 2007). .

Persons both in residential treatment and recovery houses often suffer from comorbid psychological conditions, which affect approximately 35% to 45% of the individuals. In addition, about 3 in 10 individuals are involved in the legal system—being referred to treatment, on probation, or awaiting legal processes.

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**17. What percentage of residents will have completed or still be involved in professional treatment?**

Studies to date of RRs reveal that the vast majority of RR residents have a history of inpatient or outpatient addiction treatment.

**18. What is the degree of involvement in AA, NA, and other recovery mutual support groups and institutions of persons living in recovery residences?**

The vast majority of Oxford House residents are actively involved in 12-step groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and such involvement is linked to increased social support and self-efficacy for abstinence (Majer, Jason, Ferrari, Venable, & Olson, 2002). Our experiences in working directly with this population, both clinically and as community-based researchers, have informed us that AA and NA members benefit by concurrent involvement in a sober living environment and twelve-step activities. 12-step involvement entails a set of specific behaviors that guide members of 12-Step fellowships in their recovery processes—actions outlined as "suggestions" in the fellowships' basic texts (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). These key ingredients for recovery initiation and maintenance have both theoretical and empirical support (Majer, Jason, Aase, Droege, & Ferrari, in press). Similarly, sober living houses in California either strongly encourage or mandate attendance at 12-step groups (Polcin, Korcha, Bond, & Galloway, 2010) and studies of these homes have concluded that a higher level of 12-step involvement predicts better recovery outcomes.

Early therapeutic communities (TCs) of the 1960s and 1970s were not philosophically aligned with AA, NA, or other 12-Step programs (De Leon, 2000; Yablonsky, 1965), but in recent decades, most TCs have integrated or adapted 12-Step concepts and participation in 12-Step groups into their treatment approach (White, 1998). A 1995 survey of TCs in the United States revealed that 90% had 12 Step meetings being held on their premises, with 58% encouraging 12-Step participation by their residents during treatment and 83% encouraging such participation during the aftercare phase of treatment (Troyer, Acompara, O'Connor, & Berry, 1995).

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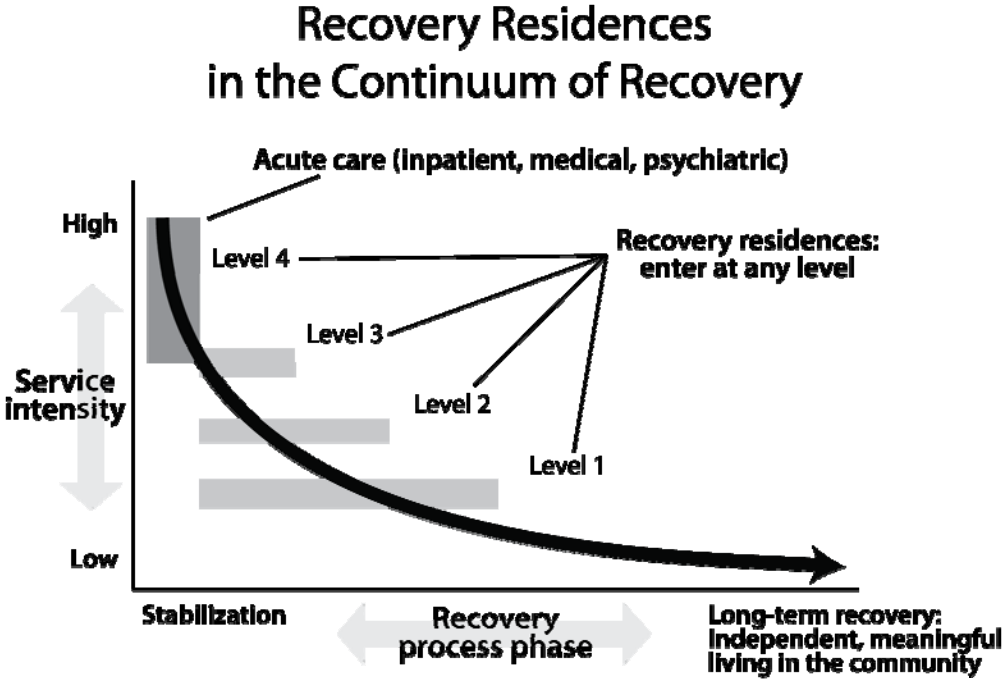
**19. How do service needs and the degree of problem severity affect admission decisions to recovery residences?**

The role that service needs and problem severity play in admissions decisions varies widely within and across levels of recovery residences (See illustration below).




There are also recovery residences designed specifically for individuals with certain needs (e.g., co-occurring addiction and severe mental illness, veterans, mothers with children); however, some recovery residences may not be equipped to adequately meet these residents' needs. Individuals with specific service needs seeking RRs should ask the provider about how these needs can (or cannot) be addressed within a particular residence.

**20. Are people taking medications (e.g., methadone, buprenorphine, other medication-assisted therapies, other prescription medications, or over-the-counter medications) accepted into recovery residences and if so, how are the medications managed?**

Yes, but medication policies vary across recovery residences. Some RRs do not accept applicants who are taking specific medications, such as narcotics and psychotropic medications; others accept residents who are being tapered down from specific medications under medical supervision; and still others fully accept persons in medication-assisted addiction treatment. Medications can be self-managed by the resident, managed by a licensed 3rd party provider, or in the case of Level 4 RRs, managed by licensed staff of the facility. Individuals seeking RR who are on medications should ask each provider about the medication policies in order to choose the RR that best fits their needs.

Both over-the-counter (OTC) and prescription medications can be abused and jeopardize an individual's recovery. Moreover, not taking medications as prescribed can undermine one's recovery. NARR requires each recovery residence (RR) to establish and clearly communicate its policy and procedures around both OTC and prescription medications. These policies and procedures are designed to maintain a safe living environment and support the recovery of everyone in the home, including the resident(s) taking medication.

There are 4 different types of RRs, each offering a different Level of Support in both services and staffing. Level 4 RRs offer clinical services whereas Levels 1, 2, and 3 do not. While laws can vary from state to state, they generally restrict the dispensing and managing of medications to licensed professionals, like the ones you would find in a Level 4 RR. That being said, most residents taking medication do not live in a Level 4 RR. Although they cannot provide medication management, Levels 1, 2, and 3 can use policies and procedures around the self-management of medications and the eligibility of individuals taking specific medications to live in the house. These policies and procedures are used to maintain a safe, recovery supportive living environment for a specific population within the scope of service an RR is qualified to provide. For example, the use of methadone, buprenorphine, and other medication-assisted recovery pharmaceuticals are allowed in some RRs, but not in others. This is in part due to the logistics, staffing, and cost of managing these types of medications, but it also may reflect philosophical differences within the recovery community and consumer choices. There is a demand for both RRs designed for individuals using medically assisted products in their recovery and for those that dis-allow medically assisted recovery.

**21. How long do people stay in a recovery residence?**

Length of stay varies depending on the residents' needs, progress, and willingness to abide by residence guidelines as well as on the payment structure of the residence. Many residences encourage a minimum length of stay or, for Level 3 and 4 residences,

have identified benchmarks set forth for residents to graduate (De Leon, 2000). Level 1 and 2 residences (e.g., Oxford Houses and Sober Living Houses) typically have an open-ended length of stay (Polcin, Korcha, Bond, & Galloway, 2010). For example, in the Oxford House model, residents can stay in the house indefinitely as long as they do not drink alcohol or use drugs and pay an equal share of the house expenses (Oxford House Inc., 2008). On average, residents stay in Oxford Houses a little more than a year, but many residents stay 3 or more years (Jason, Olson, Ferrari, & Lo Sasso, 2006).

Residents in higher Levels of Support, RR 3s and 4s, typically move to lower Levels of Support. As such, the average length of stay in RR 3s and 4s tend to be shorter than the average length of stay in RR 1s and 2s. Residences that receive payments from third parties may need to conform to guidelines set forth by these payers. For example, residents living in recovery residences that receive funding from the city of Philadelphia must receive approval to stay in the house every three months with payment limited to 90 days per individual per state fiscal year (Fred Way, Personal Communication, July 2012). Similar constraints may exist for residences that receive reimbursements from other private or public insurers.

Individuals who leave a recovery residence move out into the greater recovery community, move to different levels of support, and a few stay on as the next generation of house managers. Within many recovery residences, senior residents are developed as peer leaders and house managers—a process through which they deepen their own recovery, mentor those in early recovery, and maintain the household's recovery culture.

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**22. What happens if a resident of a recovery home uses alcohol or drugs?**

For the safety of the resident and the community, a relapse is met with immediate appropriate action. In most recovery residences, this involves moving the individual out of the RR and providing access to a level of support that will help them re-initiate recovery. Relapses can be fatal! They endanger the life of the individual and the lives of everyone else in a RR. Most RRs oppose the concept of relapse as an expected and accepted part of the recovery process as a deadly proposition that undermines recovery stabilization and maintenance (White, 2010). Relapse is a manifestation of addiction, not

of recovery; it is a sign for immediate intervention and change. NARR requires each RR to define their relapse policy and to have procedures that do not "punish" an individual for relapsing but protect the health and well-being of that individual and the RR community as a whole. All recovery residences are abstinence-based environments—in contrast to "wet housing" that allows residents to use alcohol or other drugs or "damp housing" that discourages but does not exclude persons for using.

**Reference**

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### 23. What does it cost to stay in a recovery residence?

The cost of RR varies widely and is correlated with market price of local housing and the level of support provided. Of the 4 Levels of Support identified by NARR, the higher Levels of Support tend to be more expensive because they must meet higher standards for staffing levels and services provided. However, the Levels of Support are NOT a quality rating system. A variety of services within and across Levels of Support are available to meet the recovery support and financial needs of individuals through their recovery process.

Payment terms vary, but residents can expect to pay monthly (or weekly) fees and sign an agreement committing themselves to a minimum length of stay and adhering to clearly stated house rules that support the recovery of the individual and the community. Typically, there is a refundable deposit or a non-refundable administration fee required on or before move-in. There also may be additional fees or fines clearly listed in the agreement for things like extra services or late payments.

### 24. How are recovery residences financially supported?

Most recovery residences (particularly levels 1 & 2) are self-funded through resident contribution, but recovery residences with higher levels of support, such as a range of clinical services, often receive other forms of federal, state, and private support.

RRs are historically self-funded, eventually become self-sustainable, and utilize community of volunteers. Start-up costs are typically covered by the housing provider, an Angel Investor, or a nonprofit. As a part of their recovery process, residents are expected to work, pay rent, and support the house. In some cases, residents may not be able to fully cover operational costs, so housing providers offer short-term scholarship beds and utilize other financial resources in the community. No RR could financially survive without the use of volunteer staff and peer's cultivating the culture of recovery in homes.

Start-up costs of RRs vary across the 4 Levels of Support. Lower Levels of Support, RR 1s and 2s, typically rent residential houses—a practice that avoids the capital cost of purchasing a property. The cost of capital improvements and fully furnishing a household to accommodate on average 10 residents is the largest start-up

cost. Marketing, maintenance, and utilities are the largest operational expenses for the lower Levels of Support, RR 1s and 2s. Higher Levels of Support, RR 3s and 4s, have higher staffing and administrative expenses as well as higher initial capital outlays.

In general, RRs are NOT very profitable. By the time someone is ready to embrace recovery, they have often lost the financial means to afford to live in an RR at any price. Plus, occupancy rates can be inconsistent, and operational costs can be high. It may take several years for an RR to recoup start-up costs and achieve a positive cash flow. As a result, a single financial challenge, like defining housing rights, can easily cause an RR to close.

## Recovery Residences and Recovery Outcomes (2012)

### 25. Has there been research conducted on recovery residences?

Outcomes have been reported for all four of the levels described in the National Association of Recovery Residences (NARR) Standards for Recovery Services. A selected sample of studies is discussed below on each of the levels. Studies differ in their designs and level of scientific rigor within and across the four levels. Studies that use randomized controlled designs comparing residential recovery versus control or comparison conditions are relatively limited. Most studies consist of baseline measures acquired at intake compared with the same measures administered at follow-up. Other studies use designs comparing different models of residential recovery or residential recovery programs with outpatient treatment. However, some researchers (e.g., De Leon, Inciardi, & Martin, 1995) have pointed out that the nature of long-term residential recovery settings often makes random assignment or even matching designs difficult in terms of feasibility. They suggested that an individual's process of choosing to enter a particular type of recovery residence (i.e., self-selection) was an integral part of the recovery process that should be included in designs rather than eliminated via random assignment. In other words, the sequence of: 1) learning about recovery options from family, friends, professionals, or other sources; 2) considering the pros and cons of different potential programs; and 3) deciding what type of recovery program is the best match is integral to recovery. Instead of controlling extraneous factors that might influence outcome using random assignment to different groups (i.e., recovery residence versus a control condition), they suggested the use of multivariate statistical models for longitudinal designs that can control for a wide variety of factors that might influence outcome. For a full description of these issues, see the paper by DeLeon et al. (1995) published in the *Journal of Psychoactive Drugs*. Studies by Moos (e.g., Moos & Moos, 2006) also offer good examples of nonrandomized longitudinal designs that use complex statistical models that control for extraneous influences.

#### Level I

Characteristics of Level I residences coincide most closely with Oxford Houses, which have been studied extensively by Jason et al. over the past 20 years. The brief synopsis of this work described below is taken in part from a review of non-professional recovery programs by Polcin and Borkman (2008).

Although there have been a plethora of publications resulting from the study of Oxford Houses at DePaul University, two papers present the major findings depicting longitudinal outcomes (Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006). In the earlier study, 150 individuals completing residential treatment programs were randomly assigned to aftercare as usual or residency in an Oxford House. At 24-month follow-up those assigned to the Oxford House condition had significantly better outcomes on measures of substance use, income, and incarceration. Among those assigned to aftercare as usual, 64.8% reported some alcohol or drug use over the previous 6 months versus 31.3% for the individuals assigned to the Oxford House condition. Individuals assigned to the Oxford House condition also reported lower rates of incarceration than treatment as usual, 3% versus 9%. A cost-benefit analysis by Lo Sasso, Byro, Jason, Ferrari, & Olson (2012) showed a net benefit of an Oxford House stay was on average $29,000 per person, which was significantly higher than the comparison group.

One of the limitations of the Jason et al. (2006) study was the limited geographical area from which the sample was drawn (i.e., the state of Illinois). A second limitation was the sample only included individuals completing residential treatment. The second study of Oxford houses (Jason et al., 2007) addressed both of these limitations. The study consisted of a US national sample of Oxford House residents (N=897), a majority of whom had a history of receiving some type of substance abuse treatment. However, unlike the first study, completion of a residential treatment program was not required for inclusion. Study participants were recruited from a variety of sources and interviewed at three subsequent 4-month intervals. During the final interview, only 13.5% of the respondents reported using alcohol or drugs during the previous 90 days. The average number of days participants used substances over the 90-day period was low: 3.7 days for drugs and 5.6 for alcohol. When participants reported having social networks that supported abstinence and discouraged substance use, they were more likely to be abstinent. They were also more likely to be abstinent to the extent they were involved in 12-step groups. The proportion of residents reporting employment throughout the study was high, ranging from 79% to 86%. Importantly, both longitudinal studies of Oxford Houses showed that a wide variety of persons were able to benefit. Improvement was not limited to specific demographic groups or referral sources.

**Level II**

Sober living houses (SLHs) similar to those that are members of the Sober Living Network (SLN) in Southern California and some houses affiliated with the California Association of Addiction and Recovery Resources (CAARR) are good examples of Level II residences. Like Level I residences, studies on these types of facilities have been limited.

One of the few studies on Level II residences was a recent study of houses in Northern California (Polcin, Korcha, Bond, & Galloway, 2010). Researchers recruited 245 individuals entering Clean and Sober Transitional Living in Sacramento County, which includes 16 recovery homes. The houses were located in a very high methamphetamine (MA) use area and 53% of the participants entered the houses with dependence on MA during the past year. Participants were interviewed within 2 weeks of entering the houses and then at 6-, 12- and 18-month follow-up. Primary outcomes

included measures of alcohol and drug use and Addiction Severity Index (ASI) alcohol and drug scales. Secondary measures consisted of other ASI scales and a variety instruments assessing criminal justice involvement, employment, and psychiatric problems.

Longitudinal analyses revealed two patterns for primary and some secondary outcomes over time. One pattern involved residents entering the SLHs with moderate to high severity of problems, making significant improvements by 6 months, and then maintaining those improvements at 12 and 18 months. Results from measures that assessed alcohol and drug use over a 6-month time period showed this pattern. For example, alcohol and drug abstinence over a 6-month time period increased from 20% at entry into the SLH to 40% at 6-month follow up. Abstinence improved even more at 12-month follow-up (45%) and declined only a bit at 18 months (42%).

The other outcome pattern showed residents entering the SLHs with low severity of problems at baseline and then maintaining low severity at 6-, 12-, and 18-month follow up. Findings from the ASI alcohol and drug scales were good examples of this pattern. The average score on the ASI alcohol severity at baseline was 0.16 (se=0.02), and for drug severity at baseline, the average was 0.08 (se=0.01). Because ASI values range from 0 to 1, these scores are very low. There was therefore limited room to improve on these measures. Nevertheless, there were significant improvements at 6 months for both alcohol (mean=0.10, se=0.02) and drug (mean=0.05, se=0.01) scales. Those improvements were maintained at 12 and 18 months. Alcohol severity remained at 0.10 at 12 and 18 months, and drug severity also remained essentially unchanged, 0.06 at 12 and 18 months. It should be noted that improvements were maintained at 12 and 18 months despite the fact that most residents had left the SLHs. By 18 months, about 90% of the residents had left, yet there was little regression of the earlier improvements. Thus, the improvements noted were therefore not simply a function of residents being housed in a controlled environment.

The study also examined a variety factors that predicted outcome. These included demographic characteristics and factors related to the philosophy of recovery in SLHs, such as involvement in 12-step groups and developing a social network supportive of abstinence. Generalized Estimating Equations showed that involvement in 12-step groups was the strongest and most consistent predictor of good outcome. As expected, drinking and drug use in the participant's social network predicted worse outcome.

Overall, a wide variety of demographic groups made improvement in the SLHs and only a few demographic characteristics predicted outcome. The most notable exception was the relationship between age and abstinence. Older age categories were over twice as likely to be abstinent than those aged 18-28. Relative to residents who had not completed high school, those with at least a high school diploma were nearly twice as likely to be abstinent over the past 6 months and about half as likely to be arrested.

**Level III**

A good example of level III residences are "social model" recovery programs, which emphasize experiential learning, peer support, and 12-step recovery principles within a semi-structured group living environment. These programs are more structured than level II residences and include paid counselors who assist residents with case management services and the development of a formal recovery or treatment plan.

Typically, there are various life skills and other types of groups offered at the facility. In many states, such as California, they are licensed by the state to provide treatment services.

As with Phase I and Phase II residences, the outcome studies on Phase III residences have been fairly limited. Studies that have been conducted include the California Drug and Alcohol Treatment Assessment (CALDATA; Gerstein et al., 1994) and studies on social model recovery programs conducted by Kaskutas et al. (2003-2004, 2008) at the Alcohol Research Group.

The CALDATA study examined treatment outcomes among 1,858 clients in California who received methadone treatment, non-methadone outpatient, clinically oriented residential treatment (21 providers), or social model recovery programs (23 providers). The study consisted of follow-up interviews approximately 15 months after leaving treatment. Clinically oriented residential programs included procedures such as psychiatric assessments, individual counseling, and treatment groups (e.g., therapeutic communities). Social model recovery houses were oriented toward peer support, communal living, and practicing 12-step recovery principles. Borkman, Kaskutas, Room, Bryan, & Barrows (1998) compared the two types of residential programs and reported that residents in social model programs had longer stays and incurred lower costs. Costs per treatment episode in the social model programs averaged $2,712, while costs per treatment episode in the clinical residential program averaged $4,405. Overall length of stay was associated with better outcome. Comparison of residents in the two types of residential programs who had comparable lengths of stay showed slightly better outcomes for the clinically oriented programs. For example, residents who remained in treatment 4+ months in the clinically oriented program reduced the number of months they used substances by 63% while social model residents reduced the number of months of substance use by 52%. Reductions in reports of criminal activity were slightly higher in social model programs (80%) than clinically oriented programs (74%).

Studies conducted by Kaskutas et al. (2003-2004, 2008) were stronger designs because they included longitudinal designs that compared measures collected at treatment entry with follow-up measures. The 2003-2004 study consisted of a naturalistic comparison of outcomes for individuals in social model residential programs (N=164) with those in clinically oriented programs N=558). The social model programs were detoxification and residential facilities, and the clinically oriented programs were a mix of inpatient and outpatient. Individuals in the social model programs were more involved in 12-step meetings and reported fewer alcohol and drug problems at one-year follow up, but not problems between the two study conditions in other areas (e.g., family, medical, legal, and psychiatric). The 2008 study randomly assigned clients to receive day hospital program treatment (n=154) or services in social model residential programs (n=139). Although significant improvements were noted at 12 months for both groups, between-group comparisons did not reveal significant differences. Overall, clients tended to remain in the residential programs longer and costs were higher.

**Level IV**

Relative to other levels, Level IV residences include more structure, paid professional staff, and on-site treatment services. Residential therapeutic communities (TCs) for drug treatment are a good example of Level four residences. Large proportions

of residents in TCs are referred from the criminal justice system, and some are actually located in prisons.

TCs have a long history of participating in research, including large national studies assessing drug treatment outcome. These studies include the Drug Abuse Treatment Outcome Study [DATOS] (Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997), National Treatment Improvement Evaluation Study [NTIES] (Center for Substance Abuse Treatment, 1996), Treatment Outcome Prospective Study [TOPS] (Hubbard et al., 1984), and Drug Abuse Reporting Problems [DARP] (Simpson & Friend, 1988). Overall, these and other studies on TCs (e.g., Martin, O'Commel, Paternoster, & Bachman, 2011) show that clients make longitudinal improvements on substance use measures, arrests, illegal behaviors and employment.

When TCs have been compared to voluntary, control, or alternative treatment groups, the findings have been encouraging. For example, DeLeon (1988) found that clients referred from the criminal justice system stayed in treatment longer than voluntary clients and had levels of improvement that were similar. Prendergast, Hall, Wexler, Melnick, & Cao (2004) conducted a randomized trial of 715 prisoners randomly assigned to either a therapeutic community program or to a no treatment group. At 5-year follow-up, the TC group had significantly lower *rates* of reincarceration, but not shorter times to first reincarceration. As in most studies of TCs, longer lengths of treatment were associated with better outcome. Martin, Butzin, & Inciardi (1995) studied 457 individuals participating in either an in-prison TC, a TC in the community, both types of TCs, or a no treatment comparison group. Those attending the community-based TC or both types of TC had the best outcome (substance use and re-arrest). The in-prison TC had modestly better outcomes than the no treatment comparison group.

**Summary of Outcomes**

There is obviously a significant need for additional research on residential recovery homes, especially those characterized by levels 1-3. Studies on level 4 residences are more numerous because of the large number of studies examining outcomes within therapeutic communities. Overall, the available studies across the different levels are encouraging. Longitudinal studies of residents housed within each of the levels show improvements in a range of areas. When comparisons have been made between recovery residences and appropriate alternatives, the results have shown recovery homes yield comparable or better outcomes. Cost and cost-benefit analyses have been limited and to have yielded mixed findings.

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## 26. Can the research conclusions drawn from studies of the Oxford House network be applied to all recovery residences?

The growing network of Oxford Houses represent one particular level of recovery residence—Level 1—and a particular approach to this level of recovery residence. At present, it is not known the extent to which findings reported from studies of Oxford House can be applied to other levels of care or other Level 1 recovery residences with different policies and practices than Oxford House. Until greater research is conducted on the full spectrum of recovery residences, it is not possible to know how applicable Oxford House research findings are to this broader spectrum of recovery residences.

## 27. How does living in a recovery residence influence long-term addiction recovery outcomes?

For recovery residences that fall under Levels I to III, there is very little research on long-term recovery outcomes. The primary studies on Oxford Houses (e.g., Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006) interviewed residents at 12- and 24-month follow-up. A study of sober living houses in California (Polcin, et al., 2010) interviewed residents at 18-month follow up. While these studies documented significant longitudinal improvements, it is unclear whether improvements continue at 5 or 10 years. Studies of social model residential recovery programs by Kaskutas, Zavala, Parthasarathy, & Witbrodt (2008) reported similar follow-up time frames. There is therefore a significant need for studies tracking residents over longer periods of time.

A few studies of therapeutic communities have reported somewhat longer term outcomes. For example, Prendergast, Hall, Wexler, Melnick, & Cao (2004) conducted a 5-year follow-up of individuals in a therapeutic community and found lower rates of reincarceration than a comparison group. Large national studies that included residential therapeutic community programs, such as the National Treatment Improvement

Evaluation Study (Center for Substance Abuse Treatment, 1996) and the Drug Abuse Treatment Outcome Studies (Hubbard, Craddock & Anderson, 2003) documented improvements in drug use and a variety of other areas that were maintained at 5-year follow-up, although some attrition of improvement was noted along with a variety of study limitations.

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### 28. What ingredients of the experience living in a recovery residence appear to have the greatest direct effects in elevating recovery outcomes?

Although more research is needed to isolate the specific contributions of different aspects of the RR experience to outcomes, research conducted to date points to the importance of some key factors. For example, in a national study of Oxford House residents, Jason, Davis, & Ferrari (2007) found that social support for abstinence, abstinence self-efficacy, and length of stay (6 months or longer) predicted change in cumulative abstinence, even after controlling for initial time spent in the Oxford House prior to study recruitment, leading these researchers to conclude that receiving sustained abstinence support, guidance, and information from recovery home members may reduce the probability of a relapse. Similarly, in a study of residents of Sober Living Houses in California, Polcin, Korcha, Bond, & Galloway (2010) also found that level of 12-Step involvement and social network characteristics (such as drinking and drug use status of network members) were related to improved outcomes. This is consistent with what residents themselves say is most helpful to them about living in RRs. In a mixed-methods study of Oxford House residents, Jason, Aase, Mueller, & Ferrari (2009) found that the

overwhelming majority of current and alumni members agreed that residents provide support and companionship for each other and that Oxford Houses provide motivation and increase member's sense of responsibility.

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## 29. Do outcomes differ for people with co-occurring disorders (mental health, process addictions, major medical issues such as Hep C or HIV) living in recovery residences? Are recovery residences appropriate for these populations?

Little research has been conducted that would provide answers to this question. John Majer and colleagues (2008) conducted a study on the relationship between psychiatric severity and outcomes experienced by Oxford House residents. Those residents with greater psychiatric severity were more likely to use psychiatric medications and participate in outpatient psychiatric treatment while a resident, but there were no differences between those with high and low psychiatric severity on rates of abstinence and duration of residence. While much greater research is needed on this question, preliminary OH study findings would not suggest that persons with substance use and psychiatric co-morbidity are at higher risk of relapse residing in a Level I recovery residence. (also see Majer, Jason, Ferrari, & North, 2002).

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**30. What benchmarks are used to evaluate the effectiveness of recovery residences?**

A wide variety of indicators have been used to evaluate the effectiveness of RRs, reflecting the multifaceted nature of the recovery process (The Betty Ford Consensus Panel, 2007; Cloud & Granfield, 2008; White, 2007) and how it may affect an individual's quality of life (QOL; Center for Substance Abuse Treatment, 2007). In addition to indicators of sobriety (e.g., alcohol and drug use), researchers studying the outcomes of RR residents have also assessed gains in employment, family and social functioning, psychological and emotional well-being, as well as reductions in criminal involvement (see Jason, Davis, & Ferrari, 2007 and Polcin, Korcha, Bond, & Galloway, 2010 for descriptions of measures used to assess resident outcomes). Measures of QOL have not been used in any published outcome studies of RR residents; however these measures (the WHOQOL-BREF in particular) may be useful indicators of recovery in substance abusing populations (Tracy et al., 2012).

Although clients' outcomes are central to determining the effectiveness of RRs, it is also critical to assess how well RRs may be functioning as service delivery entities and what contributes to their viability and sustainability. Research in this regard will be greatly advanced as RRs adopt the NARR standards, which along with the Oxford House Manual, provide guidelines on structure, administration, staffing, and types of services delivered in different levels of RRs. Some research has been conducted on Oxford Houses in an attempt to examine characteristics of the houses that may contribute to resident outcomes (see Ferrari, Jason, Sasser, Davis, & Olson, 2006 and Jason et al., 2008), but more work needs to be done. This type of research will greatly advance our knowledge about how RRs work as well as about what types of RRs might work best for whom.

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## 31. Are there differences among types of neighborhoods and communities relative to the sustainability of recovery residences?

Community-based programs such as recovery residences not only require the continued support and participation of their members to ensure the program's sustainability, but also the support of fellow residents of the neighborhoods and communities in which they reside (Jason et al., 2008; Zippay, 2007). Community-based programs consisting of a smaller, self-governed social model program such as the OH system might be more vulnerable to community factors than those of larger, professionally run institutional environments (Borkman et al., 2007; Polcin, 2009). This is because most professionally-run recovery residences are often vetted and licensed businesses or not-for-profit organizations (Archibald, 2007), whereas non-professional OHs require no licensures and are much more subject to the same community dynamics as ordinary housing. Therefore, it is possible that some types of neighborhoods might lead to more positive outcomes for recovery residences like OHs than other types of neighborhoods.

In general, neighborhoods with the following five characteristics should be supportive of positive outcomes for residential recovery homes such as Oxford Houses. First, these neighborhoods must have accessible, affordable rental housing in areas offering amenities for daily life. Most OHs are rental housing in suburban and working-class neighborhoods, which tend to provide stable neighbors, adequate transportation options, and local businesses necessary for daily living, and offer greater flexibility to change locations (Oxford House Inc., 2004). Secondly, Oxford Houses also require individuals in recovery willing to live together in that specific community, and to adhere to OH rules and principles (Oxford House Inc, 2004). Some neighborhoods are overly challenging in maintaining a sober lifestyle because of drug dealing or criminal activity. Third, a supportive neighborhood or community offers opportunities for residents to secure reliable employment and income for the house to become self-supporting (Jason, Olson, Ferrari, & Lo Sasso, 2006). The fourth factor for sustainable OHs consists of institutional support and enforcement of the Fair Housing Act of 1988, which prohibits discrimination against minority housing. The Act has been cited as protection against localities attempting to restrict or close down OHs via targeted zoning laws (Jason et al.,

2008; Miller, 1995). Another institutional support is the Americans with Disabilities Act of 1990, which restricts employers from discriminating against hiring former substance abusers (Zuffoletto, 1992).

The fifth and last requirement for sustainable OHs is community support. Although OH residents and their housing are protected legally, good relations can help combat NIMBY (not in my backyard) attitudes, which can lead to hostile relations between OH residents and the local, non-recovery community (Polcin, Henderson, Trocki, & Evans, 2012; Zippay, 1999). Fortunately, after some initial resistance, community acceptance for therapeutic group homes can improve over time, indicating older houses might have stronger community support (Zippay, 2007). Additional community support includes local 12-step meetings such as Alcoholics Anonymous (Groh, Jason, Ferrari, & Davis, 2009).

Laws around the regulation of addiction treatment and recovery services differ from state to state, and RR Levels of Support range from clinical to nonclinical. The availability of a particular Level of Support is reflective of state law. Even though people in recovery are a protected class under the federal Fair Housing Act and its Amendments, local governments under Not In My Back Yard (NIMBY) political pressure often times illegally discriminate against people in recovery with land use or health and safety ordinances that regulate RR above and beyond housing for individuals without a disability. This discriminatory activity raises barriers for people in recovery to access the housing that many need to live happier healthier lives. With limited resources to navigate the legal system, which can be stigmatizing into itself, RR providers are often bullied out of municipalities, leaving local people in recovery without an important resource.

Harvey, Mortensen, Aase, Jason, & Mueller (under review) found that an impressive 86.9% of Oxford Houses remained open over a period of six years, thus suggesting that OHs are relatively stable systems when they operate in supportive communities. Conversely, Calabra, Beasley, & Jason (2012) found that certain combined community characteristics (based on U.S. Census data), particularly transient communities and low SES, tended to have the greatest number of closings of OH recovery environments. Finally, Ferrari, Groh, & Jason (2009) found no differences in sobriety outcomes among OH recovery homes residents in four socio-economic zones: upper or middle class, urban working or lower class, suburban upper or middle-class, and suburban working or lower class. However, like most complex systems, residential recovery homes likely require multiple levels of neighborhood support to promote positive outcomes (Foster-Fishman, Berkowitz, & Lounsbury, 2001).

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## 32. Do recovery and family outcomes differ for parents with young children staying in recovery residences?

Many recovery home residents have children; however, few residences allow parents and children to reside in the recovery home together. Although research has recommended further exploration of children's experiences in recovery residences (Polcin, 2001), to date, few studies have examined how recovery and family outcomes differ for parents and young children who live in recovery residences.

The Oxford House model is unique in that there are designated men and children's houses as well as women and children's houses. Oxford House research has explored how children living in Oxford Houses influence aspects of the recovery process. Women who lived in Oxford Houses with children reported getting along with children in the house, that mothers could rely on other house members for babysitting help, and that the children had a positive effect on the household and the women's—both mothers and non-mothers'—recovery processes (d'Arlach, Olsen, Jason, & Ferrari, 2006). Another study compared men and women who lived with children with men and women who did not reside with children in Oxford House. This study found that men who lived with children had more general social support than women who lived with children and men who lived without children (Ortiz, Alvarez, Jason, Ferrari, & Groh, 2009). This finding suggested that women who lived with children might need additional supports and resources compared to men (Ortiz et al., 2009). These findings were similar to a prior study that found that women who had children reported many parenting-related stressors upon entry to Oxford House (Ferrari, Jason, Nelson, & Curtin-Davis, 1999).

It is essential for research to further examine longitudinal outcomes among parents and children who live in recovery residences, including settings that differ from Oxford House. Future research is also needed to explore children's experiences in recovery home settings, and how recovery homes can impact both family and recovery outcomes.

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**33. Is there a minimal optimal length of stay in a recovery residence in terms of achieving stable, sustainable recovery?**

Systematic evaluations of large-scale treatment programs, such as the Drug Abuse Treatment Outcome Studies (DATOS) carried out in 1991-1993, as well as the earlier Treatment Outcome Prospective Study (TOPS) concluded that the most consistent predictors of positive outcomes in community-based settings are client retention and length of stay (LOS; Etheridge, Craddock, & Dunteman, 1995; Simpson, 2004). Longer LOS predicted higher sobriety rates in both naturalistic, non-experimental studies (Hubbard, Craddock, & Anderson, 2003) and experimental studies with randomly assigned controls or comparison groups (Dearing, Barrick, Dermen, & Walitzer, 2005; Jason et al., 2007). However, earlier research on residential treatment settings indicated that length of stay (LOS) in treatment and aftercare has yielded contradictory results (Moos, Finney, & Cronkite, 1990). For example, McCusker and colleagues (1995) compared four groups in either a 3- or 6-month program in an enhanced TC, or a 6- or 12-month program in a traditional TC. McCusker et al. found that longer LOS in treatment has no beneficial effects than shorter LOS. All groups had the same 6-month post-treatment drug use outcomes ranging from 50% to 56% sobriety rates from drugs (alcohol use was not measured as an outcome).

It is unclear what duration and retention rates in a setting constitutes an effective LOS, and what client characteristics influence this relationship (Condelli & Hubbard, 1994; Finney, Moos, & Chan, 1981). Moos, Pettit, & Gruber (1995) found that patients ($N$ = 5,176, mostly males) who entered a long-term aftercare facility after acute or short-term AOD treatment had ended had lower treatment readmission rates after 6 months and 1 year than treated men ($N$ = 5,176) who were released back into the community, often returning to their homes. The men who entered the aftercare facility also used outpatient mental health care services significantly more than men who were released into the community. Moos et al. (1995) suggested that longer episodes of care tend to encourage active participation and involvement with mental health and recovery processes, such as more frequent office visits and meeting with recovery counselors.

Other factors undoubtedly interact with LOS. High turnover within a treatment environment might be a key component to extending resident LOS and subsequent benefits of longer treatment. In the McCusker et al. (1995) study, they found that retention rates decreased over time, ranging from 55.6% for the 3-month program to only 20.7% for the 12-month program, i.e., the longest episodes of treatment had the lowest completion rates. The low retention rates and similar use outcomes underscore the concept that length of contact with peers, rather than program length alone, is necessary for differential outcomes. It is likely that LOS cannot be equated with the intensity or "dosage" of treatment. In an evaluation of five different inpatient AOD treatment programs, Moos et al. (1990) found that client participation and involvement in the treatment milieu was at least as important as LOS. This suggests that longer stays are effective only if it permits opportunities for people recovering from AOD problems to activate the protective benefits from Moos' theoretical ingredients (Moos, 2008). Length of stay contributes to the "activation" of the theoretical ingredients because many of these

processes are time based, i.e., a 6-month program offers more opportunities to learn from peers, or to form protective bonds, than a 30-day program.

OH research indicated a tipping point of six months of residency; at a 24-month follow-up, OH residents who stayed more than six months had relapse rates of 16.6%, compared to relapse rates of 45.7% for residents staying less than six months (Jason et al., 2007). Greater LOS of six months or more may allow individuals to stabilize and adapt to their post-treatment circumstances at a self-defined pace (DiClemente, Schlundt, & Gemmell, 2004; Jason et al., 1997). Other studies have also noted that treatment durations of 6 months or more tend to produce better outcomes in residential settings (Dennis, Scott, & Foss, 2003; Hubbard et al., 2003; Johnson, Finney, & Moos, 2005). Also supporting this contention are studies comparing programs lasting from 14 to 90 days, which found no differences in sobriety outcomes based on LOS (Etheridge et al., 1995).

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### 34. Do recovery residence outcomes differ by resident characteristics, e.g., age, gender, ethnicity, co-occurring disorders, different amounts and kinds of recovery capital?

The existing literature suggests that a wide variety of individuals are able to benefit from living in a recovery residence. When differences have been found in terms of the characteristics of the types of individuals who benefit most, results have been inconsistent across studies. For example, in a study of sober living houses, Korcha, Polcin, Bond, & Galloway (2010) found higher severity of psychiatric symptoms predicted worse alcohol and drug outcomes. This finding is consistent with numerous alcohol and drug treatment studies that show co-occurring mental health disorders are common among individuals with addictive disorders, and higher psychiatric severity predicts worse outcome (e.g., Broome, Flynn, & Simpson, 1999; Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003; McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Ritsher, McKeller, Finney, Otilingam, & Moos, 2002). However, a number of studies examining outcomes of individuals in recovery residences did not find psychiatric severity to predict outcome. In a study of 52 Oxford House residents, Majer, Jason, Ferrari, & North (2002) found high co-occurrence of antisocial personality (58%), post-traumatic stress (35%), and affective (38%) disorders. Despite the high incidence of co-occurring disorders, 69% of the residents at 6-month follow up were still residing in the Oxford House or had left the house under favorable conditions. In a subsequent study of Oxford houses, Jason et al. (2007b) did not find mood or anxiety disorders to predict substance use outcomes among 75 residents of Oxford Houses.

Studies of therapeutic community residences (TCs) have also yielded mixed findings. DeLeon (1989) noted that therapeutic communities (TCs) have historically had some difficultly succeeding with clients who have co-occurring disorders. However, he outlined a series of modifications TCs have made to be more responsive to this

population, including decreased confrontation, increased flexibility, and incorporation on mental health professionals as part of the treatment team. In a recent TC study of retention, Darke, Campell, & Popple, (2012) studied 191 individuals entering a TC and did not find worse retention associated with higher psychopathology. However, Mulder, Frampton, Peka, Hampton, & Marsters (2009) studied 3-month retention among 107 individuals enrolled in a TC and found those remaining in treatment had lower mental health problems on the Short Form Health Survey (SF-36), but a higher history of lifetime depression. Samuel, LaPaglia, Maccarelli, Moore, & Ball (2011) studied how 10 different personality disorders were associated with retention in a TC. They found borderline personality disorder was associated with worse overall retention. Antisocial personality and histrionic disorders were related to very early attrition, but not overall retention.

Studies assessing demographic characteristics of individuals entering recovery residences have also yielded little that is consistent across studies. Jason, Davis, Ferrari, & Anderson (2007a) studied 897 men and women in Oxford Houses and did not find associations between demographic variables such as age, sex, and race and 90-day alcohol use. Remaining in the Oxford House for at least 6 months was a strong predictor of alcohol sobriety. However, Polcin, Korcha, Bond, & Galloway (2010a) studied sober living houses in California and found 6-month abstinence from alcohol and drugs was less common among younger individuals age 18-28 than other age groups. No differences were found by sex and race. When associations between demographic variables were examined in relation to Addiction Severity Index (ASI) alcohol and drug scales, the findings were different. There were no significant differences on the ASI drug severity scale by sex, race, or age. In addition, most comparisons on the ASI alcohol scale were also not significant, although whites and those aged 29 – 37 had somewhat lower severity. At 18-month follow-up, length of time in the sober living house did not predict outcome.

Demographic factors and how they relate to outcome have also been examined within the context of TCs. Messina, Wish, & Nemes (2000) examined a variety of predictors of outcome in TCs among women and men separately. Analysis considered a variety of demographic factors, including age, education, and marital status. For men, the only variable predicting substance use at 12 months was treatment completion predicting a negative drug screen. For women, predictors included treatment completion predicting a negative screen and a history of physical abuse predicting a positive screen. Completion of treatment was also associated with employment and avoiding arrests for both men and women. Even for residents who did not complete treatment, longer lengths of treatment were associated with better outcome, especially for women.

Examination of the role that recovery capital plays in influencing outcomes in residential recovery settings has been limited. Recovery capital refers to factors that support establishment and maintenance of recovery, such as social support, 12-step affiliation, spirituality, religiousness, and life meaning (Laudet & White, 2008). Most of these concepts are understudied among persons recovering in residential recovery homes. However, there has been some examination of social support and 12-step affiliation in Oxford and sober living houses. Polcin et al. (2010a) found higher involvement in 12-step groups and fewer heavy alcohol and drug users in the social network predicted better alcohol and drug outcomes among sober living house residents. Similar results were

found in a study of 55 individuals residing in sober living houses affiliated with an outpatient treatment program (Polcin, Korcha, Bond, & Galloway, 2010b). Groh, Jason, Ferrari, & Davis (2009) studied 12-step involvement in Oxford Houses and found high involvement in 12-step groups combined with residence in an Oxford House was associated with higher abstinence. Groh, Jason, Davis, Olson, & Ferrari (2007) found social support from family and friends predicted better alcohol outcomes for residents of Oxford Houses, but alcohol specific social support did not.

Historically, TCs have not integrated 12-step groups into the recovery process, but they have emphasized social support for recovery as an important goal. However, TCs have recently begun to modify their approach to incorporate 12-step involvement. Research by Aromin, Galanter, Solhkhah, Bunt, & Dermatis (2006) of 322 clients in TCs suggested there is increasing support for integrating 12-step groups into the TC modality. Although social support is emphasized in TCs it has been understudied as a predictor of outcome. However, in a recent study Mandell, Edelen, Wenzel, Dahl, & Ebener (2008) documented that social support capital developed early in TC treatment was associated with longer retention, and longer retention was in turn associated with better post-treatment outcomes.

Summary: There is little in the existing literature to suggest that residential recovery programs are not appropriate for specific types of individuals. When significant predictors have been found, they have not been consistent across studies. Two consistent predictors of outcome with implications for operation of recovery residences are involvement in 12-step groups and social support for recovery. Additional research is needed on predictors of outcome, especially the role of recovery capital.

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**35. Are there persons for whom recovery residences are not appropriate?**

Posing this question to those with expertise in recovery residences generates a number of anecdotal observations on populations that may not do well in this type of recovery support structure (e.g., persons with serious mental illness, persons with a past history of sexual crimes, persons with a high level of personal resources, etc.), but little research has been done on this question. There is evidence from studies of level 1 recovery residences of characteristics associated with better outcomes (e.g., persons who are older, African-American, 12-step involvement, social networks with fewer substance users and who remain in residence more than six months) (Jason, et al, 1997; 2007; Groh, et al, 2009; Polcin et al, 2010).

A RR is not appropriate for an individual:

- if they are not an eligible population. RRs are designed only for people in recovery from substance use and/or co-occurring issues. Often they are designed for an even more specific population in recovery (e.g., gender, sexual orientation, age).
- if they are unwilling or unable to support the recovery culture of the RR by adhering and upholding the house rules for themselves and others.
- if their needs exceed the scope of service provide. RR's 4 Levels of Support offer a wide range of choices, but even still, there are needs that go beyond what an RR can provide.
- if they pose a threat to themselves, others, or property.
- if they are engaged in criminal activity.

The prolonged history of harm in the name of help in the history of addiction treatment and recovery in the United States suggests the need to evaluate the potential of inadvertent harm from all helping interventions offered to individuals seeking recovery support (White, 1998; White & Kleber, 2008; White & Miller, 2007). While the potential for such harm has been explored for professionally delivered psychosocial interventions for substance use disorders (Ilgen & Moos, 2005, 2006; Moos, 2005), no studies exist to date that have identified any inadvertent harm to particular populations of people residing in the Level I-II recovery residences.

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**36. Are recovery residences cost-effective?**

Research has not thoroughly investigated the cost-effectiveness of recovery residences. The few studies that exist have compared Oxford House and alternative aftercare models. For example, an exploratory study on the societal costs of Oxford House estimated low annual societal costs per person in Oxford House based on federal and resident data (Olson et al., 2006). Additionally, the societal costs of Oxford House were relatively low when compared to costs for inpatient treatment and incarceration (Olson et al., 2006). A more recent study examined costs and benefits from a randomized, controlled study of Oxford House and usual aftercare conditions (LoSasso, Byro, Jason, Ferrari, & Olson, 2012). Economic costs included length of residency in Oxford House as well as inpatient and outpatient treatment utilization, while economic benefits encompassed monthly income, days engaged in illegal activity, substance use, and incarceration rates (LoSasso et al., 2012). Results indicated costs were higher in Oxford House, but the benefits of reduced incarceration, substance use, and illegal activity outweighed those costs (LoSasso et al., 2012).

Given the limited data on the costs and benefits of recovery residences, additional research to compare recovery residences and other types of housing arrangements is warranted. For example, future research should compare recovery residences with

government-supported housing, permanent supportive housing, transitional housing, incarceration, homelessness, safe havens, and shelters, as well as long-term residential treatment programs. Furthermore, additional data are needed to examine the combined cost savings related to criminal justice and incarceration, hospitalization and medical costs, substance use-related costs, and other social costs for recovery residences. This would include cost savings calculations for parents and families involved in child welfare systems, babies being born drug-free, and promoting intact families. Finally, it is important to incorporate the benefits of recovery residences, including residents' employment, earning incomes, pursuit of purpose, volunteer activities, and improved citizenship behaviors and how these activities impact the societal costs of these settings.

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## 37. Are government loans available to start recovery residences?

In 1988, Congress passed an "Anti-Drug Abuse Act" that included a provision to encourage state-level expansion of self-run, self-supported recovery homes, such as Oxford Houses. In early 1989, the U.S. Alcohol, Drug Abuse, and Mental Health Administration issued guidelines to all states requiring the establishment of *revolving loan funds* in which each state would set aside $100,000 from their available state funds for the expansion of these homes. Individuals were able to borrow up to $4,000 from this state loan fund to help with initial month's rent, a security deposit, and to purchase furniture and other items necessary to establish a house. Some states also provided separate financial assistance for the hiring of outreach workers or recruiters to facilitate the opening of Oxford Houses.

In a study of thirteen states that had both a revolving loan fund program and recruiters, Oxford House researchers found an increase in the opening of new houses after the introduction of these policies—a total of 559 new Oxford Houses were opened between 1988 and 2002 in these states, in contrast to no new houses being opened in the 10 years prior, suggesting that federal policy and the provision of state-level resources can affect the expansion of recovery residences (Jason, Braciszewski, Olson, & Ferrari, 2005). When the Anti-Drug Abuse Act was revised in 1999, not all states were required to offer loan funds (Braciszewski, Olson, Jason, & Ferrari, 2006). Currently, only the following locations maintain recovery home revolving loan funds: New Jersey, Illinois, Oklahoma, Nebraska, North Carolina, Washington State, Oregon, Delaware, Virginia, Kansas, Hawaii, Wyoming, New Mexico, West Virginia, and District of Columbia.

Oxford Houses across the U.S. also contribute about $300,000 a year that is used to support the development of new Oxford Houses (P. Molloy, personal communication, 21 June 2012).

More research is needed to investigate the status, effects, and implementation of these policies, particularly how they may have affected other non-Oxford House recovery residences.

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**Recovery Residences and the Community**

**38. How do Recovery Residences affect the neighborhoods in which they are located?**

The American Planning Association's *Policy Guide on Community Residences* (1997) reviewed more than 50 studies and concluded that **c**ommunity residences such as group homes and halfway houses do not have an effect on the value of neighboring properties. Reviews also note that community residences are often the best maintained homes on their block and that many neighbors were not even aware there was such a residence in the neighborhood (also see Council of Planning Librarians, 1990). Other reviews have found no negative effects on neighborhood safety and that residents of group homes are much less likely to commit a crime of any sort than the average resident (Lauber, 1986).

There are numerous reasons why RRs *should be* located in residential neighborhoods. Establishment of RRs in these areas facilitates the integration of persons in recovery back into the community and also may serve to educate the community about stigmatized populations (e.g., people with substance abuse problems, developmental disabilities, or mental illnesses). Indeed, Oxford House, Inc. advises that new houses be established in safe, low crime, economically stable neighborhoods with minimal opportunities for relapse (Oxford House, 2002), and research on Oxford Houses indicates that they are typically located in these types of neighborhoods (Ferrari, Jason, Blake, Davis, & Olson, 2006; Ferrari et al., 2009).

Despite these reasons and federal law protecting persons in recovery as a protected class under the federal Fair Housing Act and its amendments (see 42 U.S.C. §§ 3601-3619), RRs often face significant "not in my backyard" (NIMBY) opposition to opening in residential neighborhoods (Jason et al., 2008) or may be forced to open in poorer ones. For example, a study conducted in Philadelphia found that over 50% of RRs in that city were located within only 4 of the 49 city zip codes and that 26 zip codes did not have any recovery homes in them whatsoever (Johnson et al., 2009).

This sort of opposition is unfortunate, because research conducted to date generally finds that RRs do not negatively affect neighborhoods and may even provide benefits to the communities in which they are located. Interviewing landlords of Oxford Houses, Ferrari, Aase, Mueller, & Jason (2009) found that landlords reported that things such as excessive noise, rent payment, landlord tenant communication, and pet problems were less of a problem with Oxford House renters than with other renters, and many had positive comments about renting to Oxford House tenants. Studies of neighbors and community members have found similarly encouraging findings. In interviews with neighbors of Oxford Houses, Jason, Roberts, & Olson (2005) found Oxford House residents blended well into the neighborhood and made good neighbors. They also found that the majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, they found no evidence of property devaluation in the neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years.

Similar results were found by Polcin, Henderson, Trocki, Evan, & Wittman (in press) who interviewed community members about Sober Living Homes (homes comparable to NARR Level 1 and Level 2 residences) in Northern California; however, these researchers found that size and density of the house appeared to influence neighborhood perceptions. Certainly more research on community members' experiences with RRs and the factors that influence community attitudes will be useful in developing strategies to overcome NIMBY opposition to locating RRs in residential neighborhoods conducive to recovery.

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## Future Research on Recovery Residences

### 39. What are the most important questions about recovery residences that have not yet been studied?

First and foremost, we need recovery outcome and cost savings data across the Level of Support for various populations (including co-occurring, re-entry with criminal mindsets, etc.) recovering form a diversity of chemical substances in comparison to or in combination with alternative approaches. Without published research and evidence-based practice designations, licensed professionals and policymakers will continue to question the legitimacy of recovery residences and peer-based recovery.

Other critical research questions on recovery residences include:

- How many recovery residences exist in the U.S. by level of support?
- What is the geographic distribution of recovery residences in the U.S.?
- More knowledge is needed about how RRs are distributed by state or region and what differences in availability exist between urban, suburban, and rural areas.
- What factors promote the viability and sustainability of recovery residences?
- How do different characteristics of residents interact with different types of homes in different settings?
- What are the long-term effects (5 years or longer) of participation in a recovery residence?
- What are the physical, organizational, and social characteristics of the houses that are associated with the best recovery outcomes, e.g., the influence of such factors as size, architectural design, use of space, social climate within the houses, leadership, and operations?
- What are the essential components or “active ingredients” of RRs?
- How do neighborhood factors affect outcome, e.g., such factors as economic status, crime, availability of 12-step houses, and access to other services?
- How do neighborhood factors affect the start-up and sustainability of recovery residences?
- What are the major sources of referral to recovery residences?
- Are there populations for whom RRs are an alternative to addiction treatment (as opposed to an adjunct to addiction treatment)?

- How do Oxford Houses compare to other types of residences in terms of social climate and cost, e.g., the demographic and clinical characteristics of person in residence?
- What percentage of persons in RRs are continuing to participate in addiction treatment or other treatment/counseling?
- How do recovery houses and harm reduction houses differ in terms of goals, structure, outcomes, and relationships with neighbors and local government? What types of neighborhoods are a good fit for each?
- How does the ACA and other funding and policy changes affect the start-up and sustainability of recovery residences?

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# A Primer on Recovery Residences: FAQs

# from the

# National Association of Recovery Residences

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**The National Association of Recovery Residences**
**A Primer on Recovery Residences: FAQs**

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# National Association of Recovery Residences

## A Primer on Recovery Residence in the United States: FAQs

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### Introduction

Recovery residences have spread rapidly in the United States in recent decades. In 2011, the National Association of Recovery Residences (NARR) was founded to promote a recovery-oriented continuum of support for those with substance use disorders by credentialing recovery residences that implement empirically based recovery principles and practice standards. NARR currently represents more than 1,900 recovery residences in the United States. The purpose of this document is to answer some of the most frequently asked questions about recovery residences.

Answers to general questions on recovery residences were prepared by George Braucht, Jason Howell, Dave Sheridan and others on the NARR advocacy committee; answers to questions related to research on recovery residences were answered by an independent expert panel that included Leonard A. Jason, PhD, Director, Center for Community Research, DePaul University; Amy A. Mericle, PhD, Research Scientist, Treatment Research Institute; Douglas L. Polcin, EdD, Senior Scientist, Alcohol Research Group; and William L. White, MA, Senior Research Consultant, Chestnut Health Systems. Assistance in reviewing existing research was also provided by Ronald Harvey, MA, and Bronwyn Hunter, MA, DePaul University, and Fried Wittman, Ph.D., Alcohol Research Group.

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## 1. What is a recovery residence?

"Recovery residence" (RR) is a broad term describing a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems. Many thousands exist in the United States that vary in size, organization, and target population. (The exact number of recovery residences is unknown since many RRs are not regulated by government or independent organizations.) At a minimum, RRs offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence-based, long-term recovery.

Recovery residences are sober living environments, meaning that residents are expected to abstain from alcohol and illegal drug use. Each credentialed recovery residence publishes policies on relapse sanctions and readmission criteria and other rules governing group living. Recovery residences may require abstinence from particular types of medications according to individual policy.

## 2. What is the primary purpose of a recovery residence?

The purpose of a recovery residence is to provide a safe and healthy living environment to initiate and sustain recovery—defined as abstinence from alcohol and other non-prescribed drug use and improvement in one's physical, mental, spiritual, and social wellbeing. Individuals build resources while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community.

## 3. What services do recovery residences provide?

Recovery residences are divided into Levels of Support based on the type as well as the intensity and duration of support that they offer. Services provided span from peer-to-peer recovery support (all recovery residences) to medical and counseling services (recovery residences offering higher levels of support). The NARR Standards define minimum services for each Level of Support, but additional services may be provided at each level. Section 5 of the NARR Standards included in the Appendix details the minimum required service elements for each Level of Support.

## 4. How are recovery residences managed to ensure the safety of the local neighborhood and community?

Recovery residences are guided by the NARR standards that established best practices for maintaining the safety and health of the residents, the local neighborhood, and the larger community. NARR-certified recovery residences meet standards addressing safety from an administrative, operational, property, and good neighbors perspective (see Appendix).

**5. How long have recovery residences existed in the United States?**

Residences with the mission of providing support for recovery from addiction have existed in the United States since the mid-nineteenth century. The first such residence was a room established in 1841 to support members of the newly formed Washingtonian Temperance Society. In 1857, the Washingtonians opened a "home for the fallen" in Boston, which soon closed but was re-opened in 1863 as the Washingtonian Home of Boston, which evolved into one of the premier addiction treatment programs of the nineteenth century. The Washingtonian Homes in Boston and Chicago were part of a larger network of inebriate homes that existed in tandem with religiously sponsored residential inebriate colonies (e.g., Keswick Colony of Mercy), state-sponsored inebriate asylums (e.g., New York State Inebriate Asylum), and private addiction cure institutes (e.g., Keeley Institutes, Gatlin Institutes, Neal Institutes) that thrived until the passage of state and then national prohibition laws (Baumohl & Room, 1987; White, 1998).

The early inebriate homes were replaced in the opening decades of the twentieth century with private hospitals and sanitaria catering to the affluent and local "jag houses" used for detoxification and respite. These gave way in the 1940s and 1950s to the development of recovery-supportive homes, retreats, and farms associated with Alcoholics Anonymous. One factor precipitating this shift included the increased popularity and expansion of Alcoholics Anonymous. A second factor was the emergence of tighter housing markets after World War II in many metropolitan areas, which made it increasingly difficult for individuals with alcohol and drug problems to find sober living environments that supported abstinence (Wittman, Biderman, & Hughes, 1993). In the city of Los Angeles, recovering AA members opened "twelfth step" houses to address the increased need for alcohol- and drug-free living environments. Managers of these houses either mandated or strongly encouraged attendance at AA meetings. By the 1960s, Los Angeles supported several dozen such houses (Wittman, Biderman, & Hughes, 1993). Growth of the houses expanded to other parts of Southern California over subsequent decades and resulted in the creation of the Sober Living Network in 1995. The Sober Living Network currently represents 550 sober living homes in five Southern California counties.

As more state-sponsored alcoholism programs were started in the 1950s, concerns grew about how to sustain personal recovery in the transition from the institution to the community. This birthed new social institutions—the halfway house and the three-quarter-way house—that provided semi-structured residential support designed to aid community re-entry (Cahn, 1969; Raush & Raush, 1968; Rubington, 1970). Many of these programs closed due to a loss of funding as more formal community-based treatment programs increased in the 1960s and 1970s.

A more formal residential model emerged in the late 1940s and early 1950s at Pioneer House and Hazelden that became known as the "Minnesota Model." This model was subsequently medicalized and widely replicated as a residential alcoholism treatment approach throughout the U.S. and Europe (Cook, 1988; Spicer, 1993). In the 1970s, a model of recovery support akin to early Minnesota Model programs developed in California. Christened "social model programs," these programs provided an alternative to more medicalized models of treatment, but many of these programs fell under the sway

of increased professionalism and evolved into more traditional addiction treatment organizations (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Dodd, 1997).

Synanon was founded in 1958 as the first ex-addict-directed therapeutic community in the United States. This residential model of mutual support rapidly expanded in the 1960s and 1970s and was subsequently professionalized as a major addiction treatment modality (De Leon, 2000; Janzen, 2001; White, 1998). In the closing decades of the twentieth century, self-governed, financially self-supported recovery residences rapidly spread in the United States. The largest of these networks of recovery residences is Oxford House that, since its inception in 1975, has grown to 1,521 houses in 45 states with a total resident capacity of more than 12,000 (Oxford House, Inc., 2012).

Recovery residences continued to grow in the opening years of the twenty-first century sparked by both increased need (resulting in part from harsh economic conditions in many cites), the emergence of recovery as an organizing construct for the addictions field, and increased interest in recovery support institutions that could extend the benefits of addiction treatment. The history of recovery residences continues to unfold in the United States.

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## 6. How are recovery residences internally governed and externally regulated?

### 6a. How are recovery residences internally governed at the residence level?

Recovery residences' internal governance varies across NARR's Levels of Support (see Appendix). Forms of governance range from democratically run by the residents to oversight by licensed professionals.

### 6b. How are recovery residences externally regulated?

The regulation of recovery residences vary from state to state, local government to local government, and model to model. In general, states regulate professional services and local governments regulate health and safety standards. Both state and local government regulation must adhere to federal laws and limits, such as the Americans with Disabilities Act and the Fair Housing Act.

### 6c. What role do non-governmental organizations (NGO) play?

A variety of NGOs exist at the local, regional, and national level. NARR exists at the national level and partners with other organizations at the regional level. Many states/regions have NARR affiliates that maintain policies and procedures for their members that meet the NARR Standard. Identify your local affiliate by going to the NARR website: www.narronline.com.

### 6d. Are recovery residences regulated by third party payers?

Some recovery residences accept third party payments (e.g., insurance, HUD, Medicaid, etc.). Third party payers define what is reimbursable and the service duration according to mandated standards of quality and practice. Check with your payer to determine the particular coverage that is offered or contact the specific recovery residences being considered.

## 7. Are there different types of recovery residences?

Yes, there are many different types of recovery residences. Variations are found within and across all four Levels of Support (See Appendix). These levels collectively provide a spectrum of housing to best meet the unique and changing needs of individuals across the stages of long-term recovery. Recovery residences are also designed for

specific/special populations such as language, gender, women with children, age, co-occurring problems, medication status, and prison re-entry.

### 8. How can I find a local recovery residence that best meets my needs?

NARR has defined four levels of recovery support in part to assist individuals looking for facilities that match their needs. Review these levels to determine the most suitable level of support. Then contact your local/regional recovery residence association or speak to individuals active in the local recovery community for recommendations for that particular level of recovery residence. For professionals, an evidence-based placement tool for recovery residence is not available yet. However, ASAM criteria can be used to guide decisions for referral to professionally directed recovery residences.

Government telephone helplines and associated websites provide information on clinical or treatment resources but links to most recovery residences may not be provided. If you recently had a clinical assessment or were in treatment, ask the clinician for several RR recommendations. You can also search for "recovery residences in (your city or state)" on the internet. Additional sources include the telephone book; local professional organizations, faith communities, social service agencies, and resource manuals; and NARR (www.narr-online.com or email: infor@narr-online.com).

### 9. How many recovery residences exist in the United States?

To date, there has been no systematic inventory of RRs in the US. The National Survey of Substance Abuse Treatment Services (N-SSATS) represents the most comprehensive resource on facilities providing substance abuse treatment in the US. Many RRs do not consider themselves treatment facilities, and are not on the master list of organized substance abuse treatment facilities known to the Substance Abuse and Mental Health Services Administration (SAMHSA), which consists primarily of licensed, certified, or otherwise state-approved agencies (US Department of Health and Human Services, 2012). Further, even if RRs were on the master list and participated in the N-SSATS survey, it would be difficult to determine how many of the facilities surveyed identified as RRs because this is not queried as a type of service provided.

Some work to inventory RRs has been conducted by smaller regional and national associations. For example, most recent data provided by Oxford House, Inc. indicates that the current number of Oxford houses (NARR Level 1 residences) is over 1,500, having a total of 11,999 recovery beds (Oxford Grape, 2011). Their online directory lists houses currently operating in 44 states in the US (Oxford House, Inc, 2012). The State of California licenses approximately 900 level III and IV residential facilities the California Association for Addiction and Recovery Resources (CAARR) registers more than 250 sober living residences. (Susan Blacksher, California Association of Addiction Recovery Resources, Personal Communication, September 17, 2012; also see Polcin, Korcha, Bond, & Galloway, 2010). A recovery home (homes comparable to NARR Level 1 and Level 2 residences) mapping initiative conducted in Philadelphia identified 271 homes

with a service capacity for approximately 1,850 residents (Johnson, Martin, Sheahan, Way, & White, 2009).

A critical function of NARR is to serve as a national directory of recovery residences. NARR currently represents 14 associations in 14 states, plus one organization (the Association of Halfway House Alcoholism Programs, AHHAP) with national membership. As of June 2012, NARR represents approximately 1,950 residences (18 level 1, 1,265 level 2, 650 level 3, and 16 level 4) with an estimated total resident capacity of over 25,500 persons in recovery (Fred Way, Personal Communication, July 2012).

More knowledge is needed about how RRs are distributed by state or region and what differences in availability exist between urban, suburban, and rural areas. Regarding the availability of recovery residences by community income, we know access to third-party funding increases the access to RRs, and this increase is expected to be bolstered by the Affordable Care Law in 2014.

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## 10. Where are recovery residences typically located?

As mentioned earlier, RRs can be found in nearly every state in the US. Ideally, houses can be found in residential areas that provide RR residents an opportunity to integrate into the community and provide community members an opportunity to learn about RRs. Unfortunately, RRs often face significant opposition to opening in residential areas and have also been found to be concentrated in poorer residential neighborhoods (Johnson, Martin, Sheahan, & White, 2009).

Fortunately, research conducted to date among community members suggest that negative attitudes toward RRs can be overcome. For example, in interviews with community members living next to and near to Oxford Houses, Jason, Roberts, & Olson (2005) found that community members reported that Oxford House residents blended

well into the neighborhood and made good neighbors. They also found that the majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, they found no evidence of property devaluation in the neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years. Similar results were found by Polcin, Henderson, Trocki, Evan, & Wittman (in press) who interviewed community members about Sober Living Homes (homes comparable to NARR Level 1 and Level 2 residences) in Northern California; however, these researchers did find that size and density of the house appeared to influence neighborhood perceptions and that larger and more densely populated houses may need to more actively manage their relationships with community members.

Standards developed by NARR (see Appendix X) ensure that member houses (regardless of NARR level) abide by all local building and fire safety codes and that they maintain the interior and exterior of the property in a functional, safe, and clean manner that is compatible with the neighborhood. Moreover, these standards provide guidance on "good neighbor" policies to promote positive community involvement in residential neighborhoods.

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**11. Is there a national organization that represents recovery residences in the US?**

The National Association of Recovery Residences (NARR), established in 2011, currently represents approximately 1,500 residences through its local organizational affiliates. NARR advocates for recovery residences and their residents at the national and local levels. NARR members maintain standards for recovery residences of all kinds across four NARR levels of support from Level 1 peer-operated residences to Level 4 residences offering a wide variety of treatment and recovery support services. NARR is also positioned to advocate for recovery residences at the national and state level. At the state and regional level, NARR works in conjunction with affiliated recovery residence provider organizations representing individual providers. Affiliates ensure the NARR Standard is met through training and technical assistance.

Three additional recovery residence organizations exist with a national scope. The oldest is the Association of Halfway House Alcoholism Programs (AHHAP), founded in 1958, and now are affiliated with NARR. AHHAP members include all of the NARR

levels of support. AHHAP residences operate in accordance with social model recovery principles. Oxford House Inc. was established in 1975 and supports Oxford Houses internationally. Oxford Houses are NARR Level 1 residences, with each residence operated solely by the residents in accordance with Oxford House guidelines. Oxford House Inc. supports and promotes its model for peer-operated recovery residences through training, technical assistance, and access to startup financing. They also advocate for recovery housing rights and provide legal support to Oxford Houses involved in disputes with cities and towns over their right to exist. Treatment Communities of America (formerly Therapeutic Communities of America) represents more than 600 residential addiction treatment programs in the United States.

**12. Do recovery residences honor all pathways to recovery or just AA and NA? If so, how do they do that?**

Recovery residences support various abstinence-based pathways to recovery, and each residence focuses on one or more particular pathway. People seeking support for a specific, culturally congruent path to recovery should determine what recovery activities are required before accepting a placement. One key to look for is the respect shown for an individual's choices and an environment wherein residents support each other.

**13. Are residents expected to work and volunteer?**

Working and volunteering are generally considered vital components of recovery (Betty Ford Consensus Panel, 2007; Cloud & Granfield, 2008; White, 2007). Level 1 and 2 residence fees are usually paid by the residents themselves, so they must work onsite and/or offsite to meet their financial obligations. Studies of Oxford House and Sober Living House residents have found that the majority of residents are employed when they enter the residence and that employment outcomes improve over time (Jason, Davis, & Ferrari, 2007; Polcin, Korcha, Bond, & Galloway, 2010). In Level 3 and 4 residences, however, residents' time is more structured and may include numerous recovery activities during the day. In those residences, it may not be reasonable or feasible for residents to also have an outside work or volunteer activity requirement. Still, these residences, as well as Level 1 and 2 residences, may offer job readiness workshops and have relationships with local employers and community organizations to facilitate employment and volunteer involvement among residents.

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## Recovery Home Residents

### 14. How does someone get into a recovery residence?

Entry into a recovery residence usually involves an application/personal interview. Payment of first week's or first month's fees upon acceptance is common. Some residences are closely affiliated with outpatient programs and require concurrent participation in those programs. Other residences draw their residents exclusively from their own addiction treatment or mental health program.

### 15. Are there stages/tiers of participation in recovery residences?

Many residences define levels of recovery progress within the resident community. These levels are often also called phases and correspond with time in the residence, recovery progress as assessed by peers and/or staff, and the degree to which residence behavioral requirements have been met. Each level or phase is typically accompanied by an increase in privileges, greater personal autonomy, exemption from certain requirements of previous phases, and possibly different physical accommodation choices.

Many residences with this type of system often pair later phase residents with new arrivals in a sort of "buddy system." A blackout period is required in the initial phase of some recovery residences. This is a period in which the new resident is required to break communication with the outside world or with their natural supports in order to stabilize and focus on their recovery. Many residences limit the activities for new residents for a length of time after admission. These restrictions might include always being accompanied by a more senior resident when outside the home, limits to contacts with family or friends, and expectations for a higher degree of involvement in recovery support activities. Durations typically range from one week to one month.

**16. What is known about the characteristics of people living within recovery residences?**

The national profile of persons residing in all four levels of recovery homes is not presently available. The founding of NARR may provide a means of gathering that data in the future.

While residential treatment facilities and recovery homes serve all types of individuals, on average, the person is twice as likely to be male, which is consistent with SUD prevalence rates (Jason, Davis, & Ferrari, 2007; SAMHSA, 2011). For individuals undergoing residential treatment, the median age is the early thirties; however age groups from 25 to 49 are almost equally represented. The average age for a resident in a national study of Oxford House residents was 38. (Many recovery residences report that this average iage s decreasing.) Whites represent 60 to 65% of individuals in treatment and recovery homes. African Americans and Hispanics comprise 22% and 12% respectively in residential treatment (SAMHSA, 2011), In the national Oxford House Survey, Whites represented 58% of residents and Blacks and Hispanics represented 34% and 3.5% respectively (Jason, Davis & Ferrari, 2007). Existing data would suggest Hispanics are underrepresented in recovery housing when compared to these treatment statistics.

Of those individuals aged 18 or older in residential treatment, 33% had not completed high school, 42% had a high school degree, and 25% had completed some post-secondary education (SAMHSA, 2011). The average educational level for participants in a recovery residence (Oxford House) study was 12.6 years (Jason, Davis & Ferrari, 2007). Only 11% of those in residential treatment are employed either full-time or part-time; 35% are unemployed; and 54% are not in the labor force. (SAMHSA, 2011). Individuals residing in recovery homes are likely to be employed either full-time (69%) or part-time (14%), or looking for work (unemployed = 12%)(Jason, Davis & Ferrari, 2007).

Both those in residential treatment and in recovery homes are unlikely to be married. Sixty percent of the individuals have never been married, and married individuals make up about 12 to 13% of those in residential treatment (SAMHSA, 2011). For recovery home residents, about half have never been married and only 5% are currently married (Jason, Davis & Ferrari, 2007). .

Persons both in residential treatment and recovery houses often suffer from comorbid psychological conditions, which affect approximately 35% to 45% of the individuals. In addition, about 3 in 10 individuals are involved in the legal system—being referred to treatment, on probation, or awaiting legal processes.

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**17. What percentage of residents will have completed or still be involved in professional treatment?**

Studies to date of RRs reveal that the vast majority of RR residents have a history of inpatient or outpatient addiction treatment.

**18. What is the degree of involvement in AA, NA, and other recovery mutual support groups and institutions of persons living in recovery residences?**

The vast majority of Oxford House residents are actively involved in 12-step groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and such involvement is linked to increased social support and self-efficacy for abstinence (Majer, Jason, Ferrari, Venable, & Olson, 2002). Our experiences in working directly with this population, both clinically and as community-based researchers, have informed us that AA and NA members benefit by concurrent involvement in a sober living environment and twelve-step activities. 12-step involvement entails a set of specific behaviors that guide members of 12-Step fellowships in their recovery processes—actions outlined as "suggestions" in the fellowships' basic texts (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). These key ingredients for recovery initiation and maintenance have both theoretical and empirical support (Majer, Jason, Aase, Droege, & Ferrari, in press). Similarly, sober living houses in California either strongly encourage or mandate attendance at 12-step groups (Polcin, Korcha, Bond, & Galloway, 2010) and studies of these homes have concluded that a higher level of 12-step involvement predicts better recovery outcomes.

Early therapeutic communities (TCs) of the 1960s and 1970s were not philosophically aligned with AA, NA, or other 12-Step programs (De Leon, 2000; Yablonsky, 1965), but in recent decades, most TCs have integrated or adapted 12-Step concepts and participation in 12-Step groups into their treatment approach (White, 1998). A 1995 survey of TCs in the United States revealed that 90% had 12 Step meetings being held on their premises, with 58% encouraging 12-Step participation by their residents during treatment and 83% encouraging such participation during the aftercare phase of treatment (Troyer, Acompara, O'Connor, & Berry, 1995).

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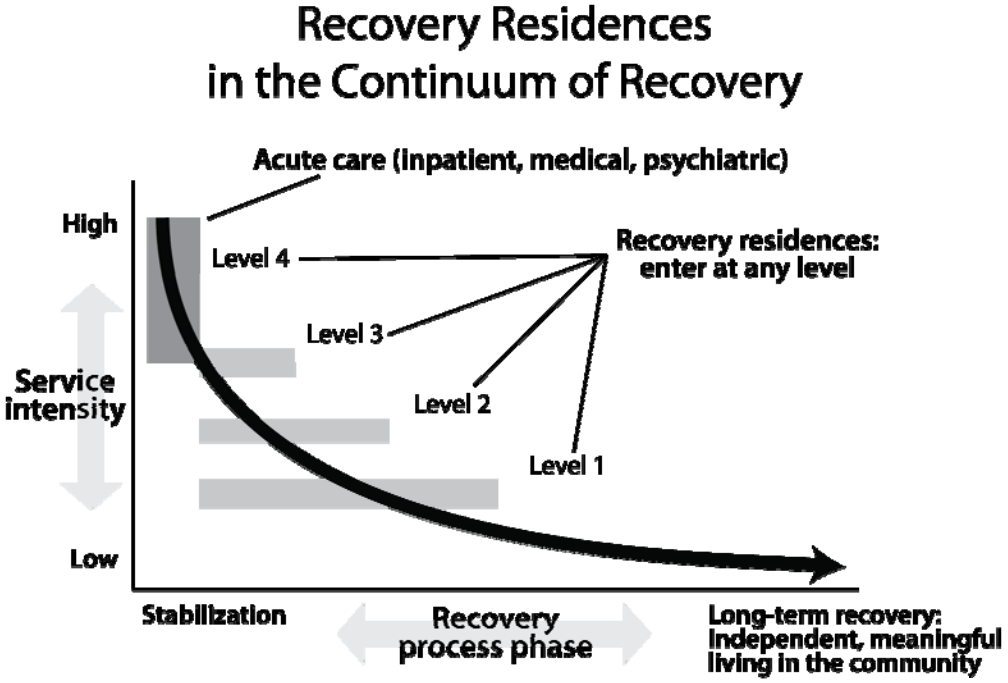
**19. How do service needs and the degree of problem severity affect admission decisions to recovery residences?**

The role that service needs and problem severity play in admissions decisions varies widely within and across levels of recovery residences (See illustration below).




There are also recovery residences designed specifically for individuals with certain needs (e.g., co-occurring addiction and severe mental illness, veterans, mothers with children); however, some recovery residences may not be equipped to adequately meet these residents' needs. Individuals with specific service needs seeking RRs should ask the provider about how these needs can (or cannot) be addressed within a particular residence.

**20. Are people taking medications (e.g., methadone, buprenorphine, other medication-assisted therapies, other prescription medications, or over-the-counter medications) accepted into recovery residences and if so, how are the medications managed?**

Yes, but medication policies vary across recovery residences. Some RRs do not accept applicants who are taking specific medications, such as narcotics and psychotropic medications; others accept residents who are being tapered down from specific medications under medical supervision; and still others fully accept persons in medication-assisted addiction treatment. Medications can be self-managed by the resident, managed by a licensed 3rd party provider, or in the case of Level 4 RRs, managed by licensed staff of the facility. Individuals seeking RR who are on medications should ask each provider about the medication policies in order to choose the RR that best fits their needs.

Both over-the-counter (OTC) and prescription medications can be abused and jeopardize an individual's recovery. Moreover, not taking medications as prescribed can undermine one's recovery. NARR requires each recovery residence (RR) to establish and clearly communicate its policy and procedures around both OTC and prescription medications. These policies and procedures are designed to maintain a safe living environment and support the recovery of everyone in the home, including the resident(s) taking medication.

There are 4 different types of RRs, each offering a different Level of Support in both services and staffing. Level 4 RRs offer clinical services whereas Levels 1, 2, and 3 do not. While laws can vary from state to state, they generally restrict the dispensing and managing of medications to licensed professionals, like the ones you would find in a Level 4 RR. That being said, most residents taking medication do not live in a Level 4 RR. Although they cannot provide medication management, Levels 1, 2, and 3 can use policies and procedures around the self-management of medications and the eligibility of individuals taking specific medications to live in the house. These policies and procedures are used to maintain a safe, recovery supportive living environment for a specific population within the scope of service an RR is qualified to provide. For example, the use of methadone, buprenorphine, and other medication-assisted recovery pharmaceuticals are allowed in some RRs, but not in others. This is in part due to the logistics, staffing, and cost of managing these types of medications, but it also may reflect philosophical differences within the recovery community and consumer choices. There is a demand for both RRs designed for individuals using medically assisted products in their recovery and for those that dis-allow medically assisted recovery.

**21. How long do people stay in a recovery residence?**

Length of stay varies depending on the residents' needs, progress, and willingness to abide by residence guidelines as well as on the payment structure of the residence. Many residences encourage a minimum length of stay or, for Level 3 and 4 residences,

have identified benchmarks set forth for residents to graduate (De Leon, 2000). Level 1 and 2 residences (e.g., Oxford Houses and Sober Living Houses) typically have an open-ended length of stay (Polcin, Korcha, Bond, & Galloway, 2010). For example, in the Oxford House model, residents can stay in the house indefinitely as long as they do not drink alcohol or use drugs and pay an equal share of the house expenses (Oxford House Inc., 2008). On average, residents stay in Oxford Houses a little more than a year, but many residents stay 3 or more years (Jason, Olson, Ferrari, & Lo Sasso, 2006).

Residents in higher Levels of Support, RR 3s and 4s, typically move to lower Levels of Support. As such, the average length of stay in RR 3s and 4s tend to be shorter than the average length of stay in RR 1s and 2s. Residences that receive payments from third parties may need to conform to guidelines set forth by these payers. For example, residents living in recovery residences that receive funding from the city of Philadelphia must receive approval to stay in the house every three months with payment limited to 90 days per individual per state fiscal year (Fred Way, Personal Communication, July 2012). Similar constraints may exist for residences that receive reimbursements from other private or public insurers.

Individuals who leave a recovery residence move out into the greater recovery community, move to different levels of support, and a few stay on as the next generation of house managers. Within many recovery residences, senior residents are developed as peer leaders and house managers—a process through which they deepen their own recovery, mentor those in early recovery, and maintain the household's recovery culture.

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**22. What happens if a resident of a recovery home uses alcohol or drugs?**

For the safety of the resident and the community, a relapse is met with immediate appropriate action. In most recovery residences, this involves moving the individual out of the RR and providing access to a level of support that will help them re-initiate recovery. Relapses can be fatal! They endanger the life of the individual and the lives of everyone else in a RR. Most RRs oppose the concept of relapse as an expected and accepted part of the recovery process as a deadly proposition that undermines recovery stabilization and maintenance (White, 2010). Relapse is a manifestation of addiction, not

of recovery; it is a sign for immediate intervention and change. NARR requires each RR to define their relapse policy and to have procedures that do not "punish" an individual for relapsing but protect the health and well-being of that individual and the RR community as a whole. All recovery residences are abstinence-based environments—in contrast to "wet housing" that allows residents to use alcohol or other drugs or "damp housing" that discourages but does not exclude persons for using.

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### 23. What does it cost to stay in a recovery residence?

The cost of RR varies widely and is correlated with market price of local housing and the level of support provided. Of the 4 Levels of Support identified by NARR, the higher Levels of Support tend to be more expensive because they must meet higher standards for staffing levels and services provided. However, the Levels of Support are NOT a quality rating system. A variety of services within and across Levels of Support are available to meet the recovery support and financial needs of individuals through their recovery process.

Payment terms vary, but residents can expect to pay monthly (or weekly) fees and sign an agreement committing themselves to a minimum length of stay and adhering to clearly stated house rules that support the recovery of the individual and the community. Typically, there is a refundable deposit or a non-refundable administration fee required on or before move-in. There also may be additional fees or fines clearly listed in the agreement for things like extra services or late payments.

### 24. How are recovery residences financially supported?

Most recovery residences (particularly levels 1 & 2) are self-funded through resident contribution, but recovery residences with higher levels of support, such as a range of clinical services, often receive other forms of federal, state, and private support.

RRs are historically self-funded, eventually become self-sustainable, and utilize community of volunteers. Start-up costs are typically covered by the housing provider, an Angel Investor, or a nonprofit. As a part of their recovery process, residents are expected to work, pay rent, and support the house. In some cases, residents may not be able to fully cover operational costs, so housing providers offer short-term scholarship beds and utilize other financial resources in the community. No RR could financially survive without the use of volunteer staff and peer's cultivating the culture of recovery in homes.

Start-up costs of RRs vary across the 4 Levels of Support. Lower Levels of Support, RR 1s and 2s, typically rent residential houses—a practice that avoids the capital cost of purchasing a property. The cost of capital improvements and fully furnishing a household to accommodate on average 10 residents is the largest start-up

cost. Marketing, maintenance, and utilities are the largest operational expenses for the lower Levels of Support, RR 1s and 2s. Higher Levels of Support, RR 3s and 4s, have higher staffing and administrative expenses as well as higher initial capital outlays.

In general, RRs are NOT very profitable. By the time someone is ready to embrace recovery, they have often lost the financial means to afford to live in an RR at any price. Plus, occupancy rates can be inconsistent, and operational costs can be high. It may take several years for an RR to recoup start-up costs and achieve a positive cash flow. As a result, a single financial challenge, like defining housing rights, can easily cause an RR to close.

## Recovery Residences and Recovery Outcomes (2012)

### 25. Has there been research conducted on recovery residences?

Outcomes have been reported for all four of the levels described in the National Association of Recovery Residences (NARR) Standards for Recovery Services. A selected sample of studies is discussed below on each of the levels. Studies differ in their designs and level of scientific rigor within and across the four levels. Studies that use randomized controlled designs comparing residential recovery versus control or comparison conditions are relatively limited. Most studies consist of baseline measures acquired at intake compared with the same measures administered at follow-up. Other studies use designs comparing different models of residential recovery or residential recovery programs with outpatient treatment. However, some researchers (e.g., De Leon, Inciardi, & Martin, 1995) have pointed out that the nature of long-term residential recovery settings often makes random assignment or even matching designs difficult in terms of feasibility. They suggested that an individual's process of choosing to enter a particular type of recovery residence (i.e., self-selection) was an integral part of the recovery process that should be included in designs rather than eliminated via random assignment. In other words, the sequence of: 1) learning about recovery options from family, friends, professionals, or other sources; 2) considering the pros and cons of different potential programs; and 3) deciding what type of recovery program is the best match is integral to recovery. Instead of controlling extraneous factors that might influence outcome using random assignment to different groups (i.e., recovery residence versus a control condition), they suggested the use of multivariate statistical models for longitudinal designs that can control for a wide variety of factors that might influence outcome. For a full description of these issues, see the paper by DeLeon et al. (1995) published in the *Journal of Psychoactive Drugs*. Studies by Moos (e.g., Moos & Moos, 2006) also offer good examples of nonrandomized longitudinal designs that use complex statistical models that control for extraneous influences.

#### Level I

Characteristics of Level I residences coincide most closely with Oxford Houses, which have been studied extensively by Jason et al. over the past 20 years. The brief synopsis of this work described below is taken in part from a review of non-professional recovery programs by Polcin and Borkman (2008).

Although there have been a plethora of publications resulting from the study of Oxford Houses at DePaul University, two papers present the major findings depicting longitudinal outcomes (Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006). In the earlier study, 150 individuals completing residential treatment programs were randomly assigned to aftercare as usual or residency in an Oxford House. At 24-month follow-up those assigned to the Oxford House condition had significantly better outcomes on measures of substance use, income, and incarceration. Among those assigned to aftercare as usual, 64.8% reported some alcohol or drug use over the previous 6 months versus 31.3% for the individuals assigned to the Oxford House condition. Individuals assigned to the Oxford House condition also reported lower rates of incarceration than treatment as usual, 3% versus 9%. A cost-benefit analysis by Lo Sasso, Byro, Jason, Ferrari, & Olson (2012) showed a net benefit of an Oxford House stay was on average $29,000 per person, which was significantly higher than the comparison group.

One of the limitations of the Jason et al. (2006) study was the limited geographical area from which the sample was drawn (i.e., the state of Illinois). A second limitation was the sample only included individuals completing residential treatment. The second study of Oxford houses (Jason et al., 2007) addressed both of these limitations. The study consisted of a US national sample of Oxford House residents (N=897), a majority of whom had a history of receiving some type of substance abuse treatment. However, unlike the first study, completion of a residential treatment program was not required for inclusion. Study participants were recruited from a variety of sources and interviewed at three subsequent 4-month intervals. During the final interview, only 13.5% of the respondents reported using alcohol or drugs during the previous 90 days. The average number of days participants used substances over the 90-day period was low: 3.7 days for drugs and 5.6 for alcohol. When participants reported having social networks that supported abstinence and discouraged substance use, they were more likely to be abstinent. They were also more likely to be abstinent to the extent they were involved in 12-step groups. The proportion of residents reporting employment throughout the study was high, ranging from 79% to 86%. Importantly, both longitudinal studies of Oxford Houses showed that a wide variety of persons were able to benefit. Improvement was not limited to specific demographic groups or referral sources.

**Level II**

Sober living houses (SLHs) similar to those that are members of the Sober Living Network (SLN) in Southern California and some houses affiliated with the California Association of Addiction and Recovery Resources (CAARR) are good examples of Level II residences. Like Level I residences, studies on these types of facilities have been limited.

One of the few studies on Level II residences was a recent study of houses in Northern California (Polcin, Korcha, Bond, & Galloway, 2010). Researchers recruited 245 individuals entering Clean and Sober Transitional Living in Sacramento County, which includes 16 recovery homes. The houses were located in a very high methamphetamine (MA) use area and 53% of the participants entered the houses with dependence on MA during the past year. Participants were interviewed within 2 weeks of entering the houses and then at 6-, 12- and 18-month follow-up. Primary outcomes

included measures of alcohol and drug use and Addiction Severity Index (ASI) alcohol and drug scales. Secondary measures consisted of other ASI scales and a variety instruments assessing criminal justice involvement, employment, and psychiatric problems.

Longitudinal analyses revealed two patterns for primary and some secondary outcomes over time. One pattern involved residents entering the SLHs with moderate to high severity of problems, making significant improvements by 6 months, and then maintaining those improvements at 12 and 18 months. Results from measures that assessed alcohol and drug use over a 6-month time period showed this pattern. For example, alcohol and drug abstinence over a 6-month time period increased from 20% at entry into the SLH to 40% at 6-month follow up. Abstinence improved even more at 12-month follow-up (45%) and declined only a bit at 18 months (42%).

The other outcome pattern showed residents entering the SLHs with low severity of problems at baseline and then maintaining low severity at 6-, 12-, and 18-month follow up. Findings from the ASI alcohol and drug scales were good examples of this pattern. The average score on the ASI alcohol severity at baseline was 0.16 (se=0.02), and for drug severity at baseline, the average was 0.08 (se=0.01). Because ASI values range from 0 to 1, these scores are very low. There was therefore limited room to improve on these measures. Nevertheless, there were significant improvements at 6 months for both alcohol (mean=0.10, se=0.02) and drug (mean=0.05, se=0.01) scales. Those improvements were maintained at 12 and 18 months. Alcohol severity remained at 0.10 at 12 and 18 months, and drug severity also remained essentially unchanged, 0.06 at 12 and 18 months. It should be noted that improvements were maintained at 12 and 18 months despite the fact that most residents had left the SLHs. By 18 months, about 90% of the residents had left, yet there was little regression of the earlier improvements. Thus, the improvements noted were therefore not simply a function of residents being housed in a controlled environment.

The study also examined a variety factors that predicted outcome. These included demographic characteristics and factors related to the philosophy of recovery in SLHs, such as involvement in 12-step groups and developing a social network supportive of abstinence. Generalized Estimating Equations showed that involvement in 12-step groups was the strongest and most consistent predictor of good outcome. As expected, drinking and drug use in the participant's social network predicted worse outcome.

Overall, a wide variety of demographic groups made improvement in the SLHs and only a few demographic characteristics predicted outcome. The most notable exception was the relationship between age and abstinence. Older age categories were over twice as likely to be abstinent than those aged 18-28. Relative to residents who had not completed high school, those with at least a high school diploma were nearly twice as likely to be abstinent over the past 6 months and about half as likely to be arrested.

**Level III**

A good example of level III residences are "social model" recovery programs, which emphasize experiential learning, peer support, and 12-step recovery principles within a semi-structured group living environment. These programs are more structured than level II residences and include paid counselors who assist residents with case management services and the development of a formal recovery or treatment plan.

Typically, there are various life skills and other types of groups offered at the facility. In many states, such as California, they are licensed by the state to provide treatment services.

As with Phase I and Phase II residences, the outcome studies on Phase III residences have been fairly limited. Studies that have been conducted include the California Drug and Alcohol Treatment Assessment (CALDATA; Gerstein et al., 1994) and studies on social model recovery programs conducted by Kaskutas et al. (2003-2004, 2008) at the Alcohol Research Group.

The CALDATA study examined treatment outcomes among 1,858 clients in California who received methadone treatment, non-methadone outpatient, clinically oriented residential treatment (21 providers), or social model recovery programs (23 providers). The study consisted of follow-up interviews approximately 15 months after leaving treatment. Clinically oriented residential programs included procedures such as psychiatric assessments, individual counseling, and treatment groups (e.g., therapeutic communities). Social model recovery houses were oriented toward peer support, communal living, and practicing 12-step recovery principles. Borkman, Kaskutas, Room, Bryan, & Barrows (1998) compared the two types of residential programs and reported that residents in social model programs had longer stays and incurred lower costs. Costs per treatment episode in the social model programs averaged $2,712, while costs per treatment episode in the clinical residential program averaged $4,405. Overall length of stay was associated with better outcome. Comparison of residents in the two types of residential programs who had comparable lengths of stay showed slightly better outcomes for the clinically oriented programs. For example, residents who remained in treatment 4+ months in the clinically oriented program reduced the number of months they used substances by 63% while social model residents reduced the number of months of substance use by 52%. Reductions in reports of criminal activity were slightly higher in social model programs (80%) than clinically oriented programs (74%).

Studies conducted by Kaskutas et al. (2003-2004, 2008) were stronger designs because they included longitudinal designs that compared measures collected at treatment entry with follow-up measures. The 2003-2004 study consisted of a naturalistic comparison of outcomes for individuals in social model residential programs (N=164) with those in clinically oriented programs N=558). The social model programs were detoxification and residential facilities, and the clinically oriented programs were a mix of inpatient and outpatient. Individuals in the social model programs were more involved in 12-step meetings and reported fewer alcohol and drug problems at one-year follow up, but not problems between the two study conditions in other areas (e.g., family, medical, legal, and psychiatric). The 2008 study randomly assigned clients to receive day hospital program treatment (n=154) or services in social model residential programs (n=139). Although significant improvements were noted at 12 months for both groups, between-group comparisons did not reveal significant differences. Overall, clients tended to remain in the residential programs longer and costs were higher.

**Level IV**

Relative to other levels, Level IV residences include more structure, paid professional staff, and on-site treatment services. Residential therapeutic communities (TCs) for drug treatment are a good example of Level four residences. Large proportions

of residents in TCs are referred from the criminal justice system, and some are actually located in prisons.

TCs have a long history of participating in research, including large national studies assessing drug treatment outcome. These studies include the Drug Abuse Treatment Outcome Study [DATOS] (Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997), National Treatment Improvement Evaluation Study [NTIES] (Center for Substance Abuse Treatment, 1996), Treatment Outcome Prospective Study [TOPS] (Hubbard et al., 1984), and Drug Abuse Reporting Problems [DARP] (Simpson & Friend, 1988). Overall, these and other studies on TCs (e.g., Martin, O'Commel, Paternoster, & Bachman, 2011) show that clients make longitudinal improvements on substance use measures, arrests, illegal behaviors and employment.

When TCs have been compared to voluntary, control, or alternative treatment groups, the findings have been encouraging. For example, DeLeon (1988) found that clients referred from the criminal justice system stayed in treatment longer than voluntary clients and had levels of improvement that were similar. Prendergast, Hall, Wexler, Melnick, & Cao (2004) conducted a randomized trial of 715 prisoners randomly assigned to either a therapeutic community program or to a no treatment group. At 5-year follow-up, the TC group had significantly lower *rates* of reincarceration, but not shorter times to first reincarceration. As in most studies of TCs, longer lengths of treatment were associated with better outcome. Martin, Butzin, & Inciardi (1995) studied 457 individuals participating in either an in-prison TC, a TC in the community, both types of TCs, or a no treatment comparison group. Those attending the community-based TC or both types of TC had the best outcome (substance use and re-arrest). The in-prison TC had modestly better outcomes than the no treatment comparison group.

**Summary of Outcomes**

There is obviously a significant need for additional research on residential recovery homes, especially those characterized by levels 1-3. Studies on level 4 residences are more numerous because of the large number of studies examining outcomes within therapeutic communities. Overall, the available studies across the different levels are encouraging. Longitudinal studies of residents housed within each of the levels show improvements in a range of areas. When comparisons have been made between recovery residences and appropriate alternatives, the results have shown recovery homes yield comparable or better outcomes. Cost and cost-benefit analyses have been limited and to have yielded mixed findings.

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## 26. Can the research conclusions drawn from studies of the Oxford House network be applied to all recovery residences?

The growing network of Oxford Houses represent one particular level of recovery residence—Level 1—and a particular approach to this level of recovery residence. At present, it is not known the extent to which findings reported from studies of Oxford House can be applied to other levels of care or other Level 1 recovery residences with different policies and practices than Oxford House. Until greater research is conducted on the full spectrum of recovery residences, it is not possible to know how applicable Oxford House research findings are to this broader spectrum of recovery residences.

## 27. How does living in a recovery residence influence long-term addiction recovery outcomes?

For recovery residences that fall under Levels I to III, there is very little research on long-term recovery outcomes. The primary studies on Oxford Houses (e.g., Jason, Davis, Ferrari, & Anderson, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006) interviewed residents at 12- and 24-month follow-up. A study of sober living houses in California (Polcin, et al., 2010) interviewed residents at 18-month follow up. While these studies documented significant longitudinal improvements, it is unclear whether improvements continue at 5 or 10 years. Studies of social model residential recovery programs by Kaskutas, Zavala, Parthasarathy, & Witbrodt (2008) reported similar follow-up time frames. There is therefore a significant need for studies tracking residents over longer periods of time.

A few studies of therapeutic communities have reported somewhat longer term outcomes. For example, Prendergast, Hall, Wexler, Melnick, & Cao (2004) conducted a 5-year follow-up of individuals in a therapeutic community and found lower rates of reincarceration than a comparison group. Large national studies that included residential therapeutic community programs, such as the National Treatment Improvement

Evaluation Study (Center for Substance Abuse Treatment, 1996) and the Drug Abuse Treatment Outcome Studies (Hubbard, Craddock & Anderson, 2003) documented improvements in drug use and a variety of other areas that were maintained at 5-year follow-up, although some attrition of improvement was noted along with a variety of study limitations.

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### 28. What ingredients of the experience living in a recovery residence appear to have the greatest direct effects in elevating recovery outcomes?

Although more research is needed to isolate the specific contributions of different aspects of the RR experience to outcomes, research conducted to date points to the importance of some key factors. For example, in a national study of Oxford House residents, Jason, Davis, & Ferrari (2007) found that social support for abstinence, abstinence self-efficacy, and length of stay (6 months or longer) predicted change in cumulative abstinence, even after controlling for initial time spent in the Oxford House prior to study recruitment, leading these researchers to conclude that receiving sustained abstinence support, guidance, and information from recovery home members may reduce the probability of a relapse. Similarly, in a study of residents of Sober Living Houses in California, Polcin, Korcha, Bond, & Galloway (2010) also found that level of 12-Step involvement and social network characteristics (such as drinking and drug use status of network members) were related to improved outcomes. This is consistent with what residents themselves say is most helpful to them about living in RRs. In a mixed-methods study of Oxford House residents, Jason, Aase, Mueller, & Ferrari (2009) found that the

overwhelming majority of current and alumni members agreed that residents provide support and companionship for each other and that Oxford Houses provide motivation and increase member's sense of responsibility.

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## 29. Do outcomes differ for people with co-occurring disorders (mental health, process addictions, major medical issues such as Hep C or HIV) living in recovery residences? Are recovery residences appropriate for these populations?

Little research has been conducted that would provide answers to this question. John Majer and colleagues (2008) conducted a study on the relationship between psychiatric severity and outcomes experienced by Oxford House residents. Those residents with greater psychiatric severity were more likely to use psychiatric medications and participate in outpatient psychiatric treatment while a resident, but there were no differences between those with high and low psychiatric severity on rates of abstinence and duration of residence. While much greater research is needed on this question, preliminary OH study findings would not suggest that persons with substance use and psychiatric co-morbidity are at higher risk of relapse residing in a Level I recovery residence. (also see Majer, Jason, Ferrari, & North, 2002).

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**30. What benchmarks are used to evaluate the effectiveness of recovery residences?**

A wide variety of indicators have been used to evaluate the effectiveness of RRs, reflecting the multifaceted nature of the recovery process (The Betty Ford Consensus Panel, 2007; Cloud & Granfield, 2008; White, 2007) and how it may affect an individual's quality of life (QOL; Center for Substance Abuse Treatment, 2007). In addition to indicators of sobriety (e.g., alcohol and drug use), researchers studying the outcomes of RR residents have also assessed gains in employment, family and social functioning, psychological and emotional well-being, as well as reductions in criminal involvement (see Jason, Davis, & Ferrari, 2007 and Polcin, Korcha, Bond, & Galloway, 2010 for descriptions of measures used to assess resident outcomes). Measures of QOL have not been used in any published outcome studies of RR residents; however these measures (the WHOQOL-BREF in particular) may be useful indicators of recovery in substance abusing populations (Tracy et al., 2012).

Although clients' outcomes are central to determining the effectiveness of RRs, it is also critical to assess how well RRs may be functioning as service delivery entities and what contributes to their viability and sustainability. Research in this regard will be greatly advanced as RRs adopt the NARR standards, which along with the Oxford House Manual, provide guidelines on structure, administration, staffing, and types of services delivered in different levels of RRs. Some research has been conducted on Oxford Houses in an attempt to examine characteristics of the houses that may contribute to resident outcomes (see Ferrari, Jason, Sasser, Davis, & Olson, 2006 and Jason et al., 2008), but more work needs to be done. This type of research will greatly advance our knowledge about how RRs work as well as about what types of RRs might work best for whom.

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## 31. Are there differences among types of neighborhoods and communities relative to the sustainability of recovery residences?

Community-based programs such as recovery residences not only require the continued support and participation of their members to ensure the program's sustainability, but also the support of fellow residents of the neighborhoods and communities in which they reside (Jason et al., 2008; Zippay, 2007). Community-based programs consisting of a smaller, self-governed social model program such as the OH system might be more vulnerable to community factors than those of larger, professionally run institutional environments (Borkman et al., 2007; Polcin, 2009). This is because most professionally-run recovery residences are often vetted and licensed businesses or not-for-profit organizations (Archibald, 2007), whereas non-professional OHs require no licensures and are much more subject to the same community dynamics as ordinary housing. Therefore, it is possible that some types of neighborhoods might lead to more positive outcomes for recovery residences like OHs than other types of neighborhoods.

In general, neighborhoods with the following five characteristics should be supportive of positive outcomes for residential recovery homes such as Oxford Houses. First, these neighborhoods must have accessible, affordable rental housing in areas offering amenities for daily life. Most OHs are rental housing in suburban and working-class neighborhoods, which tend to provide stable neighbors, adequate transportation options, and local businesses necessary for daily living, and offer greater flexibility to change locations (Oxford House Inc., 2004). Secondly, Oxford Houses also require individuals in recovery willing to live together in that specific community, and to adhere to OH rules and principles (Oxford House Inc, 2004). Some neighborhoods are overly challenging in maintaining a sober lifestyle because of drug dealing or criminal activity. Third, a supportive neighborhood or community offers opportunities for residents to secure reliable employment and income for the house to become self-supporting (Jason, Olson, Ferrari, & Lo Sasso, 2006). The fourth factor for sustainable OHs consists of institutional support and enforcement of the Fair Housing Act of 1988, which prohibits discrimination against minority housing. The Act has been cited as protection against localities attempting to restrict or close down OHs via targeted zoning laws (Jason et al.,

2008; Miller, 1995). Another institutional support is the Americans with Disabilities Act of 1990, which restricts employers from discriminating against hiring former substance abusers (Zuffoletto, 1992).

The fifth and last requirement for sustainable OHs is community support. Although OH residents and their housing are protected legally, good relations can help combat NIMBY (not in my backyard) attitudes, which can lead to hostile relations between OH residents and the local, non-recovery community (Polcin, Henderson, Trocki, & Evans, 2012; Zippay, 1999). Fortunately, after some initial resistance, community acceptance for therapeutic group homes can improve over time, indicating older houses might have stronger community support (Zippay, 2007). Additional community support includes local 12-step meetings such as Alcoholics Anonymous (Groh, Jason, Ferrari, & Davis, 2009).

Laws around the regulation of addiction treatment and recovery services differ from state to state, and RR Levels of Support range from clinical to nonclinical. The availability of a particular Level of Support is reflective of state law. Even though people in recovery are a protected class under the federal Fair Housing Act and its Amendments, local governments under Not In My Back Yard (NIMBY) political pressure often times illegally discriminate against people in recovery with land use or health and safety ordinances that regulate RR above and beyond housing for individuals without a disability. This discriminatory activity raises barriers for people in recovery to access the housing that many need to live happier healthier lives. With limited resources to navigate the legal system, which can be stigmatizing into itself, RR providers are often bullied out of municipalities, leaving local people in recovery without an important resource.

Harvey, Mortensen, Aase, Jason, & Mueller (under review) found that an impressive 86.9% of Oxford Houses remained open over a period of six years, thus suggesting that OHs are relatively stable systems when they operate in supportive communities. Conversely, Calabra, Beasley, & Jason (2012) found that certain combined community characteristics (based on U.S. Census data), particularly transient communities and low SES, tended to have the greatest number of closings of OH recovery environments. Finally, Ferrari, Groh, & Jason (2009) found no differences in sobriety outcomes among OH recovery homes residents in four socio-economic zones: upper or middle class, urban working or lower class, suburban upper or middle-class, and suburban working or lower class. However, like most complex systems, residential recovery homes likely require multiple levels of neighborhood support to promote positive outcomes (Foster-Fishman, Berkowitz, & Lounsbury, 2001).

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## 32. Do recovery and family outcomes differ for parents with young children staying in recovery residences?

Many recovery home residents have children; however, few residences allow parents and children to reside in the recovery home together. Although research has recommended further exploration of children's experiences in recovery residences (Polcin, 2001), to date, few studies have examined how recovery and family outcomes differ for parents and young children who live in recovery residences.

The Oxford House model is unique in that there are designated men and children's houses as well as women and children's houses. Oxford House research has explored how children living in Oxford Houses influence aspects of the recovery process. Women who lived in Oxford Houses with children reported getting along with children in the house, that mothers could rely on other house members for babysitting help, and that the children had a positive effect on the household and the women's—both mothers and non-mothers'—recovery processes (d'Arlach, Olsen, Jason, & Ferrari, 2006). Another study compared men and women who lived with children with men and women who did not reside with children in Oxford House. This study found that men who lived with children had more general social support than women who lived with children and men who lived without children (Ortiz, Alvarez, Jason, Ferrari, & Groh, 2009). This finding suggested that women who lived with children might need additional supports and resources compared to men (Ortiz et al., 2009). These findings were similar to a prior study that found that women who had children reported many parenting-related stressors upon entry to Oxford House (Ferrari, Jason, Nelson, & Curtin-Davis, 1999).

It is essential for research to further examine longitudinal outcomes among parents and children who live in recovery residences, including settings that differ from Oxford House. Future research is also needed to explore children's experiences in recovery home settings, and how recovery homes can impact both family and recovery outcomes.

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**33. Is there a minimal optimal length of stay in a recovery residence in terms of achieving stable, sustainable recovery?**

Systematic evaluations of large-scale treatment programs, such as the Drug Abuse Treatment Outcome Studies (DATOS) carried out in 1991-1993, as well as the earlier Treatment Outcome Prospective Study (TOPS) concluded that the most consistent predictors of positive outcomes in community-based settings are client retention and length of stay (LOS; Etheridge, Craddock, & Dunteman, 1995; Simpson, 2004). Longer LOS predicted higher sobriety rates in both naturalistic, non-experimental studies (Hubbard, Craddock, & Anderson, 2003) and experimental studies with randomly assigned controls or comparison groups (Dearing, Barrick, Dermen, & Walitzer, 2005; Jason et al., 2007). However, earlier research on residential treatment settings indicated that length of stay (LOS) in treatment and aftercare has yielded contradictory results (Moos, Finney, & Cronkite, 1990). For example, McCusker and colleagues (1995) compared four groups in either a 3- or 6-month program in an enhanced TC, or a 6- or 12-month program in a traditional TC. McCusker et al. found that longer LOS in treatment has no beneficial effects than shorter LOS. All groups had the same 6-month post-treatment drug use outcomes ranging from 50% to 56% sobriety rates from drugs (alcohol use was not measured as an outcome).

It is unclear what duration and retention rates in a setting constitutes an effective LOS, and what client characteristics influence this relationship (Condelli & Hubbard, 1994; Finney, Moos, & Chan, 1981). Moos, Pettit, & Gruber (1995) found that patients ($N$ = 5,176, mostly males) who entered a long-term aftercare facility after acute or short-term AOD treatment had ended had lower treatment readmission rates after 6 months and 1 year than treated men ($N$ = 5,176) who were released back into the community, often returning to their homes. The men who entered the aftercare facility also used outpatient mental health care services significantly more than men who were released into the community. Moos et al. (1995) suggested that longer episodes of care tend to encourage active participation and involvement with mental health and recovery processes, such as more frequent office visits and meeting with recovery counselors.

Other factors undoubtedly interact with LOS. High turnover within a treatment environment might be a key component to extending resident LOS and subsequent benefits of longer treatment. In the McCusker et al. (1995) study, they found that retention rates decreased over time, ranging from 55.6% for the 3-month program to only 20.7% for the 12-month program, i.e., the longest episodes of treatment had the lowest completion rates. The low retention rates and similar use outcomes underscore the concept that length of contact with peers, rather than program length alone, is necessary for differential outcomes. It is likely that LOS cannot be equated with the intensity or "dosage" of treatment. In an evaluation of five different inpatient AOD treatment programs, Moos et al. (1990) found that client participation and involvement in the treatment milieu was at least as important as LOS. This suggests that longer stays are effective only if it permits opportunities for people recovering from AOD problems to activate the protective benefits from Moos' theoretical ingredients (Moos, 2008). Length of stay contributes to the "activation" of the theoretical ingredients because many of these

processes are time based, i.e., a 6-month program offers more opportunities to learn from peers, or to form protective bonds, than a 30-day program.

OH research indicated a tipping point of six months of residency; at a 24-month follow-up, OH residents who stayed more than six months had relapse rates of 16.6%, compared to relapse rates of 45.7% for residents staying less than six months (Jason et al., 2007). Greater LOS of six months or more may allow individuals to stabilize and adapt to their post-treatment circumstances at a self-defined pace (DiClemente, Schlundt, & Gemmell, 2004; Jason et al., 1997). Other studies have also noted that treatment durations of 6 months or more tend to produce better outcomes in residential settings (Dennis, Scott, & Foss, 2003; Hubbard et al., 2003; Johnson, Finney, & Moos, 2005). Also supporting this contention are studies comparing programs lasting from 14 to 90 days, which found no differences in sobriety outcomes based on LOS (Etheridge et al., 1995).

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### 34. Do recovery residence outcomes differ by resident characteristics, e.g., age, gender, ethnicity, co-occurring disorders, different amounts and kinds of recovery capital?

The existing literature suggests that a wide variety of individuals are able to benefit from living in a recovery residence. When differences have been found in terms of the characteristics of the types of individuals who benefit most, results have been inconsistent across studies. For example, in a study of sober living houses, Korcha, Polcin, Bond, & Galloway (2010) found higher severity of psychiatric symptoms predicted worse alcohol and drug outcomes. This finding is consistent with numerous alcohol and drug treatment studies that show co-occurring mental health disorders are common among individuals with addictive disorders, and higher psychiatric severity predicts worse outcome (e.g., Broome, Flynn, & Simpson, 1999; Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003; McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Ritsher, McKeller, Finney, Otilingam, & Moos, 2002). However, a number of studies examining outcomes of individuals in recovery residences did not find psychiatric severity to predict outcome. In a study of 52 Oxford House residents, Majer, Jason, Ferrari, & North (2002) found high co-occurrence of antisocial personality (58%), post-traumatic stress (35%), and affective (38%) disorders. Despite the high incidence of co-occurring disorders, 69% of the residents at 6-month follow up were still residing in the Oxford House or had left the house under favorable conditions. In a subsequent study of Oxford houses, Jason et al. (2007b) did not find mood or anxiety disorders to predict substance use outcomes among 75 residents of Oxford Houses.

Studies of therapeutic community residences (TCs) have also yielded mixed findings. DeLeon (1989) noted that therapeutic communities (TCs) have historically had some difficultly succeeding with clients who have co-occurring disorders. However, he outlined a series of modifications TCs have made to be more responsive to this

population, including decreased confrontation, increased flexibility, and incorporation on mental health professionals as part of the treatment team. In a recent TC study of retention, Darke, Campell, & Popple, (2012) studied 191 individuals entering a TC and did not find worse retention associated with higher psychopathology. However, Mulder, Frampton, Peka, Hampton, & Marsters (2009) studied 3-month retention among 107 individuals enrolled in a TC and found those remaining in treatment had lower mental health problems on the Short Form Health Survey (SF-36), but a higher history of lifetime depression. Samuel, LaPaglia, Maccarelli, Moore, & Ball (2011) studied how 10 different personality disorders were associated with retention in a TC. They found borderline personality disorder was associated with worse overall retention. Antisocial personality and histrionic disorders were related to very early attrition, but not overall retention.

Studies assessing demographic characteristics of individuals entering recovery residences have also yielded little that is consistent across studies. Jason, Davis, Ferrari, & Anderson (2007a) studied 897 men and women in Oxford Houses and did not find associations between demographic variables such as age, sex, and race and 90-day alcohol use. Remaining in the Oxford House for at least 6 months was a strong predictor of alcohol sobriety. However, Polcin, Korcha, Bond, & Galloway (2010a) studied sober living houses in California and found 6-month abstinence from alcohol and drugs was less common among younger individuals age 18-28 than other age groups. No differences were found by sex and race. When associations between demographic variables were examined in relation to Addiction Severity Index (ASI) alcohol and drug scales, the findings were different. There were no significant differences on the ASI drug severity scale by sex, race, or age. In addition, most comparisons on the ASI alcohol scale were also not significant, although whites and those aged 29 – 37 had somewhat lower severity. At 18-month follow-up, length of time in the sober living house did not predict outcome.

Demographic factors and how they relate to outcome have also been examined within the context of TCs. Messina, Wish, & Nemes (2000) examined a variety of predictors of outcome in TCs among women and men separately. Analysis considered a variety of demographic factors, including age, education, and marital status. For men, the only variable predicting substance use at 12 months was treatment completion predicting a negative drug screen. For women, predictors included treatment completion predicting a negative screen and a history of physical abuse predicting a positive screen. Completion of treatment was also associated with employment and avoiding arrests for both men and women. Even for residents who did not complete treatment, longer lengths of treatment were associated with better outcome, especially for women.

Examination of the role that recovery capital plays in influencing outcomes in residential recovery settings has been limited. Recovery capital refers to factors that support establishment and maintenance of recovery, such as social support, 12-step affiliation, spirituality, religiousness, and life meaning (Laudet & White, 2008). Most of these concepts are understudied among persons recovering in residential recovery homes. However, there has been some examination of social support and 12-step affiliation in Oxford and sober living houses. Polcin et al. (2010a) found higher involvement in 12-step groups and fewer heavy alcohol and drug users in the social network predicted better alcohol and drug outcomes among sober living house residents. Similar results were

found in a study of 55 individuals residing in sober living houses affiliated with an outpatient treatment program (Polcin, Korcha, Bond, & Galloway, 2010b). Groh, Jason, Ferrari, & Davis (2009) studied 12-step involvement in Oxford Houses and found high involvement in 12-step groups combined with residence in an Oxford House was associated with higher abstinence. Groh, Jason, Davis, Olson, & Ferrari (2007) found social support from family and friends predicted better alcohol outcomes for residents of Oxford Houses, but alcohol specific social support did not.

Historically, TCs have not integrated 12-step groups into the recovery process, but they have emphasized social support for recovery as an important goal. However, TCs have recently begun to modify their approach to incorporate 12-step involvement. Research by Aromin, Galanter, Solhkhah, Bunt, & Dermatis (2006) of 322 clients in TCs suggested there is increasing support for integrating 12-step groups into the TC modality. Although social support is emphasized in TCs it has been understudied as a predictor of outcome. However, in a recent study Mandell, Edelen, Wenzel, Dahl, & Ebener (2008) documented that social support capital developed early in TC treatment was associated with longer retention, and longer retention was in turn associated with better post-treatment outcomes.

Summary: There is little in the existing literature to suggest that residential recovery programs are not appropriate for specific types of individuals. When significant predictors have been found, they have not been consistent across studies. Two consistent predictors of outcome with implications for operation of recovery residences are involvement in 12-step groups and social support for recovery. Additional research is needed on predictors of outcome, especially the role of recovery capital.

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**35. Are there persons for whom recovery residences are not appropriate?**

Posing this question to those with expertise in recovery residences generates a number of anecdotal observations on populations that may not do well in this type of recovery support structure (e.g., persons with serious mental illness, persons with a past history of sexual crimes, persons with a high level of personal resources, etc.), but little research has been done on this question. There is evidence from studies of level 1 recovery residences of characteristics associated with better outcomes (e.g., persons who are older, African-American, 12-step involvement, social networks with fewer substance users and who remain in residence more than six months) (Jason, et al, 1997; 2007; Groh, et al, 2009; Polcin et al, 2010).

A RR is not appropriate for an individual:

- if they are not an eligible population. RRs are designed only for people in recovery from substance use and/or co-occurring issues. Often they are designed for an even more specific population in recovery (e.g., gender, sexual orientation, age).
- if they are unwilling or unable to support the recovery culture of the RR by adhering and upholding the house rules for themselves and others.
- if their needs exceed the scope of service provide. RR's 4 Levels of Support offer a wide range of choices, but even still, there are needs that go beyond what an RR can provide.
- if they pose a threat to themselves, others, or property.
- if they are engaged in criminal activity.

The prolonged history of harm in the name of help in the history of addiction treatment and recovery in the United States suggests the need to evaluate the potential of inadvertent harm from all helping interventions offered to individuals seeking recovery support (White, 1998; White & Kleber, 2008; White & Miller, 2007). While the potential for such harm has been explored for professionally delivered psychosocial interventions for substance use disorders (Ilgen & Moos, 2005, 2006; Moos, 2005), no studies exist to date that have identified any inadvertent harm to particular populations of people residing in the Level I-II recovery residences.

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**36. Are recovery residences cost-effective?**

Research has not thoroughly investigated the cost-effectiveness of recovery residences. The few studies that exist have compared Oxford House and alternative aftercare models. For example, an exploratory study on the societal costs of Oxford House estimated low annual societal costs per person in Oxford House based on federal and resident data (Olson et al., 2006). Additionally, the societal costs of Oxford House were relatively low when compared to costs for inpatient treatment and incarceration (Olson et al., 2006). A more recent study examined costs and benefits from a randomized, controlled study of Oxford House and usual aftercare conditions (LoSasso, Byro, Jason, Ferrari, & Olson, 2012). Economic costs included length of residency in Oxford House as well as inpatient and outpatient treatment utilization, while economic benefits encompassed monthly income, days engaged in illegal activity, substance use, and incarceration rates (LoSasso et al., 2012). Results indicated costs were higher in Oxford House, but the benefits of reduced incarceration, substance use, and illegal activity outweighed those costs (LoSasso et al., 2012).

Given the limited data on the costs and benefits of recovery residences, additional research to compare recovery residences and other types of housing arrangements is warranted. For example, future research should compare recovery residences with

government-supported housing, permanent supportive housing, transitional housing, incarceration, homelessness, safe havens, and shelters, as well as long-term residential treatment programs. Furthermore, additional data are needed to examine the combined cost savings related to criminal justice and incarceration, hospitalization and medical costs, substance use-related costs, and other social costs for recovery residences. This would include cost savings calculations for parents and families involved in child welfare systems, babies being born drug-free, and promoting intact families. Finally, it is important to incorporate the benefits of recovery residences, including residents' employment, earning incomes, pursuit of purpose, volunteer activities, and improved citizenship behaviors and how these activities impact the societal costs of these settings.

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## 37. Are government loans available to start recovery residences?

In 1988, Congress passed an "Anti-Drug Abuse Act" that included a provision to encourage state-level expansion of self-run, self-supported recovery homes, such as Oxford Houses. In early 1989, the U.S. Alcohol, Drug Abuse, and Mental Health Administration issued guidelines to all states requiring the establishment of *revolving loan funds* in which each state would set aside $100,000 from their available state funds for the expansion of these homes. Individuals were able to borrow up to $4,000 from this state loan fund to help with initial month's rent, a security deposit, and to purchase furniture and other items necessary to establish a house. Some states also provided separate financial assistance for the hiring of outreach workers or recruiters to facilitate the opening of Oxford Houses.

In a study of thirteen states that had both a revolving loan fund program and recruiters, Oxford House researchers found an increase in the opening of new houses after the introduction of these policies—a total of 559 new Oxford Houses were opened between 1988 and 2002 in these states, in contrast to no new houses being opened in the 10 years prior, suggesting that federal policy and the provision of state-level resources can affect the expansion of recovery residences (Jason, Braciszewski, Olson, & Ferrari, 2005). When the Anti-Drug Abuse Act was revised in 1999, not all states were required to offer loan funds (Braciszewski, Olson, Jason, & Ferrari, 2006). Currently, only the following locations maintain recovery home revolving loan funds: New Jersey, Illinois, Oklahoma, Nebraska, North Carolina, Washington State, Oregon, Delaware, Virginia, Kansas, Hawaii, Wyoming, New Mexico, West Virginia, and District of Columbia.

Oxford Houses across the U.S. also contribute about $300,000 a year that is used to support the development of new Oxford Houses (P. Molloy, personal communication, 21 June 2012).

More research is needed to investigate the status, effects, and implementation of these policies, particularly how they may have affected other non-Oxford House recovery residences.

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**Recovery Residences and the Community**

**38. How do Recovery Residences affect the neighborhoods in which they are located?**

The American Planning Association's *Policy Guide on Community Residences* (1997) reviewed more than 50 studies and concluded that **c**ommunity residences such as group homes and halfway houses do not have an effect on the value of neighboring properties. Reviews also note that community residences are often the best maintained homes on their block and that many neighbors were not even aware there was such a residence in the neighborhood (also see Council of Planning Librarians, 1990). Other reviews have found no negative effects on neighborhood safety and that residents of group homes are much less likely to commit a crime of any sort than the average resident (Lauber, 1986).

There are numerous reasons why RRs *should be* located in residential neighborhoods. Establishment of RRs in these areas facilitates the integration of persons in recovery back into the community and also may serve to educate the community about stigmatized populations (e.g., people with substance abuse problems, developmental disabilities, or mental illnesses). Indeed, Oxford House, Inc. advises that new houses be established in safe, low crime, economically stable neighborhoods with minimal opportunities for relapse (Oxford House, 2002), and research on Oxford Houses indicates that they are typically located in these types of neighborhoods (Ferrari, Jason, Blake, Davis, & Olson, 2006; Ferrari et al., 2009).

Despite these reasons and federal law protecting persons in recovery as a protected class under the federal Fair Housing Act and its amendments (see 42 U.S.C. §§ 3601-3619), RRs often face significant "not in my backyard" (NIMBY) opposition to opening in residential neighborhoods (Jason et al., 2008) or may be forced to open in poorer ones. For example, a study conducted in Philadelphia found that over 50% of RRs in that city were located within only 4 of the 49 city zip codes and that 26 zip codes did not have any recovery homes in them whatsoever (Johnson et al., 2009).

This sort of opposition is unfortunate, because research conducted to date generally finds that RRs do not negatively affect neighborhoods and may even provide benefits to the communities in which they are located. Interviewing landlords of Oxford Houses, Ferrari, Aase, Mueller, & Jason (2009) found that landlords reported that things such as excessive noise, rent payment, landlord tenant communication, and pet problems were less of a problem with Oxford House renters than with other renters, and many had positive comments about renting to Oxford House tenants. Studies of neighbors and community members have found similarly encouraging findings. In interviews with neighbors of Oxford Houses, Jason, Roberts, & Olson (2005) found Oxford House residents blended well into the neighborhood and made good neighbors. They also found that the majority of Oxford House neighbors interviewed had either gained resources, friendships, or a greater sense of security following contact with the Oxford House residents. Furthermore, they found no evidence of property devaluation in the neighborhoods containing Oxford Houses; community members who knew of the Oxford House actually saw an increase in property value over an average of 3 years.

Similar results were found by Polcin, Henderson, Trocki, Evan, & Wittman (in press) who interviewed community members about Sober Living Homes (homes comparable to NARR Level 1 and Level 2 residences) in Northern California; however, these researchers found that size and density of the house appeared to influence neighborhood perceptions. Certainly more research on community members' experiences with RRs and the factors that influence community attitudes will be useful in developing strategies to overcome NIMBY opposition to locating RRs in residential neighborhoods conducive to recovery.

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## Future Research on Recovery Residences

### 39. What are the most important questions about recovery residences that have not yet been studied?

First and foremost, we need recovery outcome and cost savings data across the Level of Support for various populations (including co-occurring, re-entry with criminal mindsets, etc.) recovering form a diversity of chemical substances in comparison to or in combination with alternative approaches. Without published research and evidence-based practice designations, licensed professionals and policymakers will continue to question the legitimacy of recovery residences and peer-based recovery.

Other critical research questions on recovery residences include:

- How many recovery residences exist in the U.S. by level of support?
- What is the geographic distribution of recovery residences in the U.S.?
- More knowledge is needed about how RRs are distributed by state or region and what differences in availability exist between urban, suburban, and rural areas.
- What factors promote the viability and sustainability of recovery residences?
- How do different characteristics of residents interact with different types of homes in different settings?
- What are the long-term effects (5 years or longer) of participation in a recovery residence?
- What are the physical, organizational, and social characteristics of the houses that are associated with the best recovery outcomes, e.g., the influence of such factors as size, architectural design, use of space, social climate within the houses, leadership, and operations?
- What are the essential components or “active ingredients” of RRs?
- How do neighborhood factors affect outcome, e.g., such factors as economic status, crime, availability of 12-step houses, and access to other services?
- How do neighborhood factors affect the start-up and sustainability of recovery residences?
- What are the major sources of referral to recovery residences?
- Are there populations for whom RRs are an alternative to addiction treatment (as opposed to an adjunct to addiction treatment)?

- How do Oxford Houses compare to other types of residences in terms of social climate and cost, e.g., the demographic and clinical characteristics of person in residence?
- What percentage of persons in RRs are continuing to participate in addiction treatment or other treatment/counseling?
- How do recovery houses and harm reduction houses differ in terms of goals, structure, outcomes, and relationships with neighbors and local government? What types of neighborhoods are a good fit for each?
- How does the ACA and other funding and policy changes affect the start-up and sustainability of recovery residences?

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# Selected Papers of William L. White

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**Citation**: Groshkova T, Best D, White W. (2012). The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug & Alcohol Review*, 1-8. Posted at **www.williamwhitepapers.com**

## The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths

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***** Chestnut Health Systems, Bloomington, Illinois, USA**

### Abstract

**Introduction and Aims:** Sociological work on social capital and its impact on health behaviours have been translated into the addiction field in the form of 'recovery capital' as the construct for assessing individual progress on a recovery journey. Yet there has been little attempt to quantify recovery capital. The aim of the project was to create a scale that assessed addiction recovery capital.

**Design and Methods:** Initial focus group work identified and tested candidate items and domains followed by data collection from multiple sources to enable psychometric assessment of a scale measuring recovery capital.

**Results:** The scale shows moderate test–retest reliability at 1 week and acceptable concurrent validity. Principal component analysis determined single factor structure.

**Discussion and Conclusions:** The Assessment of Recovery Capital (ARC) is a brief and easy to administer measurement of recovery capital that has acceptable psychometric properties and may be a useful complement to deficit-based assessment and outcome monitoring instruments for substance dependent individuals in and out of treatment.

**Key words:** addiction, recovery capital measure, assessment, psychometrics.



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## Recovery Management Service Design Matrices

**William L. White, MA, Arthur C. Evans, Jr., PhD, and Ijeoma Achara-Abrahams, PsyD**

The acute care (AC) model of intervention has dominated specialized addiction treatment since its inception in the mid-nineteenth century. According to White & McLellan (2008), the AC Model is distinguished by the following characteristics:

- Services are delivered "programmatically" in a uniform series of encapsulated activities (screening, admission, a point-in-time assessment, a short course of minimally individualized treatment, discharge, and brief "aftercare" followed by termination of the service relationship).
- The intervention is focused specifically on symptom elimination of the substance use disorder.
- Professional experts direct and dominate the assessment, treatment planning, service delivery, and service termination decision-making.
- Services transpire over a short (and historically ever-shorter) period of time, usually as a function of a pre-arranged, time-limited insurance payment designed specifically for substance use disorders and "carved out" from general medical insurance.
- The individual/family/community is given the impression at discharge ("graduation") that long-term recovery is personally self-sustainable without ongoing professional assistance.
- The intervention is evaluated at a short-term, single point-in-time follow-up that compares pre-treatment status with discharge status and post-treatment status.
- Post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the individual rather than as potential flaws in the design or execution of the treatment protocol.

There are increasing calls to extend this AC model into more encompassing models of sustained recovery management (RM) and to nest these RM models within larger recovery-oriented systems of care (ROSC).

*Recovery management* is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery identification and engagement, recovery initiation and stabilization, the transition to long-term recovery maintenance, and the quality of personal/family life in long-term recovery as well as break intergenerational cycles of problem transmission via

the integration of prevention, early intervention, treatment, and recovery support activities (White, 2008b).

The phrase r*ecovery-oriented systems of care* refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in ROSC is not a federal, state, or local agency, but a macro level organization of the larger cultural and community environment in which long-term addiction recovery is nested (White, 2008b).

The AC and RM models are not mutually exclusive; RM incorporates AC expertise in biopsychosocial stabilization and recovery initiation, and many AC models, when called upon to increase their recovery orientation, respond by developing an isolated RM-oriented service component (additive approach) or applying RM principles and methods to only one particular program or level of care (selective approach) rather than fundamentally redesigning the service system (transformative approach; Achara-Abrahams, Evans, & King, 2011).

The authors are often asked what system characteristics and service practices change in the transition to RM and ROSC. The purpose of this paper is to chart such changes in a series of brief tables that can be used for easy reference.

## Service Infrastructure

There are many infrastructure elements needed within and shared in common between AC and RM/ROSC models of care. For example, both AC- and RM-oriented organizations operate best with a foundation of organizational health and stability, adequate capitalization and funding diversification, recognized status as a local service institution, and technological sophistication (White, 2008b). But there are distinct differences when we compare the service infrastructures of AC- and RM/ROSC-oriented organizations. Examples of these differences are highlighted in Table 1.

**Table 1: RM & ROSC Changes in Service Infrastructure**

| Service Infrastructure Dimension | Prevailing AC Model | Emerging RM Service Model |
|---|---|---|
| Recovery Representation & Orientation | Low recovery representation (e.g., eroding recovery representation among board, management, staff, & volunteers) and recovery orientation (decreased focus on long-term recovery processes and outcomes) through era of modern addiction treatment; recent efforts to revitalize recovery orientation. | Emphasis on authentic recovery representation at all levels of system: governing boards, advisory councils, leadership roles, staff, and volunteers. Recovery orientation evident by recovery-focused mission statements, recovery-focused service practices (e.g., practice guidelines), and relationships with local recovery communities. |
| Service Integration | Categorical service segregation (specialized addiction treatment services with weak linkages to broader health and human service network) & weak relationships with culturally indigenous | Reciprocal integration of mental health services, primary health care, and addiction treatment; focus on developing other cross system partnerships; emphasis on nesting recovery within natural community environments of those served via strong |

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| | (non-professional) institutions & healers. | relationships with indigenous institutions/healers. |
| Service Design | Discrete, disconnected system initiatives (e.g., evidence-based practices initiative, trauma informed care initiative, behavioral health primary care integration) and programs, with no over-arching framework to tie them together. | ROSC serves as the overarching framework for the development of everything in the service system. The values and principles embedded in the RM approach inform all initiatives and services so that they are part of a larger recovery-oriented context. Strong emphasis on connecting and integrating initiatives. |
| System Leadership | Strong emphasis on management and hierarchy. Management processes focus on ongoing operations, budgeting, coordinating, monitoring, and problem solving. | Leadership is emphasized and viewed as distinct from management processes. Leadership focuses on developing a vision of the future; aligning people, practices, and processes with that vision; and inspiring people to embrace and pursue the vision. |
| Service Funding | Service designs dictated by funding restrictions of private managed behavioral health care organizations and public funders; categorical funding of clinical services delivered by traditional addiction treatment providers. Funding is allocated based on historical funding patterns. Almost all service dollars are focused on treatment to traditional providers. Non-clinical supports and alternative services not viewed as important. | Newly developed recovery-focused service guidelines of public managed behavioral health care organizations; expanded funding to deliver recovery support services through non-traditional service providers, e.g., recovery community organizations, health clinics, faith ministries; mini-grants specifically to enhance recovery orientation of treatment programs. Funding is allocated based on the expressed needs and desires of people receiving services and those practices identified as supporting recovery. |
| Systems Relationship | Hierarchical influence based on authority, control, and fear (e.g., threatened loss of funding); we-they polarizations at multiple systems levels. | Influence based on mutual respect and partnership; efforts to transition historically conflicted/competitive relationships to collaborative relationships. |
| Workforce Development | Minimal investment in workforce development, high workforce turnover; replication of abandonment & loss experiences of clients. | Considerable recovery-focused education, training, and supervision provided; emphasis on workforce retention & leadership development; |

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| | | investment in leadership development for people in recovery. |
| Performance Improvement (PI) | PI processes not a focal point of the system. When they are used, they are limited to typical utilization data (e.g., access, retention, graduation rates). Data is used primarily for reporting. Emphasis is on symptoms of addiction (i.e., recidivism, arrests, etc). Data is not used to improve the service system's capacity to support sustained recovery. Data collection is limited to quantitative service system data with minimal direct feedback from people in recovery and families, and there are few feedback loops with the providers. Performance improvement focuses on the process of treatment (e.g., numbers served) and symptom management as the primary outcome. | PI processes are used to shape provider practices. What you look at is different (e.g., in addition to typical utilization data, also include recovery-oriented practices, e.g., extent to which people involved in directing their treatment and recovery plans, existence of service menus, and also improvements in global health). Why you look at certain data points is different (e.g., recidivism is used not as a marker for engagement in treatment, but engagement in long-term recovery), and how you collect the data is different (e.g., in addition to quantitative service data, also collect qualitative data via focus groups with people in recovery). PI processes incentivize and support RM approaches through pay for performance initiatives and continuous feedback loops, etc. |
| Systems & Service Evaluation | System evaluation focuses primarily on process measures, e.g., the number of units of service, or the number of people served. Limited outcome evaluations focus on the short-term evaluation of degree to which services can subtract from lives of those served, e.g., reduction in drug use, crime, social costs, threats to public health. People in recovery and family members are minimally involved in system evaluation processes. | Focus on long-term outcomes that evaluate what services can add to individual, family, and community life, e.g., sobriety, global health, community reintegration, and social contribution; quality of personal/family life; cost-offsets seen as by-products of recovery not primary purpose of service provision. The perspectives of people in recovery and family members are actively sought and they play a central role in evaluation processes (e.g., conducting focus groups, etc.). To the extent that process is evaluated, the emphasis is on known correlates of successful recovery initiation and management. |

**Changes in Service Practices**

Following brief presentations of the authors on RM/ROSC, we often hear comments like "We're already recovery-oriented" or "This recovery stuff is just new buzzwords for the same thing we've always been doing." The more detailed the comparison between AC and RM/ROSC models, the less we hear such comments. Table 2 illustrates some of the fundamental changes that occur in frontline service practices in the transition between an exclusively AC model of care and an RM/ROSC approach to service design.

**Table 2: RM and ROSC Changes in Service Practices**

| Service Dimension | Prevailing AC Service Model | Emerging RM Service Model |
|---|---|---|
| Attraction | Passive reliance on referrals from formal community organizations, marketing aimed primarily at service institutions. | Assertive outreach (e.g., hospitals, jails, street outreach teams, faith-based organizations, natural healers, etc.). |
| Access | Restricted by waiting lists, layers of administrative intake, limited hours of service provision, geographical inaccessibility. | Assertive lowering of barriers to access (e.g., waiting list management, co-location of services, pre-treatment peer support groups, education of natural supports to promote early identification, etc.). |
| Engagement | High rates of service attrition via exclusion, early disengagement, and extrusion (more than 50% not completing a course of treatment). | Emphasis on engagement, retention, and outreach and re-engagement of those who disengage from service. Lower thresholds of engagement; warm welcome; assertive service prompts. Continued AOD use during treatment results in reengagement and altering service plan rather than administrative discharge. |
| Assessment | Problem-specific, problem-focused, conducted as an intake or initial service planning function; unit of service is the individual entering treatment. | Focused on multiple life domains, strengths-based (recovery capital—assets as well as challenges), emphasis on self-assessment, continual; unit of assessment is person, family, and community. |
| Service Planning Format | Professionally directed Treatment Plan; emphasis on need for professional control and direction; limited choice; limited variation in treatment plans. | Rapid transition from treatment plan to person-directed recovery plan; or development of person-directed recovery plan that includes a treatment plan; emphasis on philosophy of choice; considerable variation in recovery plans. |
| Level of Care Placement | Decided primarily by problem severity, duration, and complexity. | Decided based on ratio of recovery capital to problem severity, duration, and complexity and |

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| | | expressed preference of person/family. |
| Composition of Service Team | Composed primarily of addiction counselors. | Expanded to include much greater role for physicians, psychologists, social workers, recovery support specialists, family, and indigenous healers from the community (e.g., spiritual advisors); much greater use of alumni and recovery volunteers. |
| Service Relationship | Professional model, e.g., professional diagnoses and treats; person's role is treatment adherence; relationships hierarchical, transient, and highly commercialized. | Partnership model, e.g., person forges their own long-term recovery plan with professional serving as consultant in each person's development and execution of the recovery plan; focus on helping each person/family develop recovery support relationships that are natural, reciprocal, and potentially enduring. |
| Service Scope | Set "program" (fixed sequence of addiction-specific services) with limited individual variation. The services are determined by the professionals. | Ever-expanding service menu that is combined and sequenced with considerable variation from person to person. The menu of services is informed by and frequently modified based on the expressed needs, interests, and preferences of the people being served. |
| Service Duration | Brief intervention focused primarily on the stage of recovery initiation and stabilization followed by termination of the service relationship. | Sustained recovery support potentially spanning pre-recovery identification and engagement, recovery initiation and stabilization, transition to stable recovery maintenance, enhanced quality of personal/family life in long-term recovery, and efforts to break intergenerational cycles of problem transmission. |
| Service Quality | Efforts underway to implement evidence-based practices (EBP). The implementation of EBPs is often focused around symptom reduction and stabilization. | Emphasis on evidence-based practices and practice-based evidence with service participants having a major voice in definitions of quality. EBPs implemented and embedded in the context of a recovery management approach. They are viewed as tools in a more comprehensive toolkit and the focus of implementation is on sustained recovery and increased quality of life. |

| | | |
|---|---|---|
| Locus of Service Delivery | Services primarily institution-based—person must leave his/her world and enter professional milieu. | Greater emphasis on reaching people in their natural environments, e.g., home-based, neighborhood-based service delivery; greater use of technology for service delivery and long-term recovery support. |
| Linkage to Recovery Community Resources | Ranges from no linkage to passive linkage (e.g., verbal encouragement to attend recovery mutual aid meetings, provision of a meeting list). | Assertive linkage to a broad spectrum of recovery support institutions and activities, including opportunities for recovery advocacy. Assertive efforts to identify the best fit between individuals and the available recovery community resources. Close organizational ties between treatment institution and indigenous recovery community institutions, e.g., recovery mutual aid service committees, recovery community organizations, recovery homes/schools/industries/ministries, etc. |
| Post-treatment Contact | Passive continuing care, e.g., weekly continuing care group available at treatment institution for persons who successfully completed treatment, discharge planning towards the end of a treatment episode. | Assertive continuing care (post-treatment monitoring & support—recovery checkups, stage-appropriate recovery education, linkage to recovery support resource, and if needed, early re-intervention) for all persons admitted to treatment, regardless of discharge status. Planning for continuing support initiated early in the treatment process. Building connections to community recovery capital becomes a focus of the treatment process based on identified needs. |
| Service Evaluation | Focus on short-term abstinence outcomes and reduction in social costs outcomes. | Focus on long-term recovery outcomes as measured by abstinence or remission, improvements in global health, and positive community reintegration. |

**The Community as Client: Integration of Clinical Models of Intervention with Cultural Revitalization and Community Development Models**

AC models of intervention into AOD problems are based exclusively on clinical interventions primarily with the individual and, at their best, with families. RM/ROSC models of care seek not only to target interventions at the community level to support personal/family

recovery but also to heal wounds within the larger community that have been inflicted by AOD-related problems. Within RM/ROSC approaches, the community is also a client. Table 3 illustrates some of the goals and representative activities within this community-level intervention process.

**Table 3: Community Mobilization Strategies within RM & ROSC**

| Recovery-focused Community Mobilization Goals | Representative Activities |
|---|---|
| Mobilize local recovery communities as a force for education, advocacy, peer recovery support, and community service. | • Establishing a Recovery Advisory Council.<br>• Hosting national speakers for recovery community events; public recovery celebration events (e.g., annual recovery walk).<br>• Sponsoring storytelling, recovery coaching, and leadership training workshops.<br>• Supporting development of community recovery centers as hubs for education, advocacy, peer support, and community service.<br>• Encouraging development of treatment alumni associations.<br>• Offering technical assistance to local organizations on how to recruit, select, orient, train, and supervise recovery volunteers.<br>• Inviting participation in public advocacy by people in recovery who are temperamentally suited for this role and whose life circumstances minimize the risk of personal/family harm that might accrue from this activity. |
| Enhance diversity and quality of recovery support resources. | • Inventorying and mapping local recovery support resources.<br>• Measuring and reporting changes in community recovery capital over time.<br>• Ensuring recovery support resources are located in geographical areas of greatest need.<br>• Strengthening relationships between local treatment programs and mutual aid group service committees.<br>• Supporting the development of indigenous recovery support resources across diverse ethnic and cultural communities.<br>• Providing seed money and technical support for development of new recovery support institutions, e.g., recovery homes/schools/industries/ministries. |

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| | • Developing and disseminating educational materials that affirm the legitimacy of diverse secular, spiritual, and religious pathways of recovery.<br>• Creating pathways of involvement for people in medication-assisted recovery to participate in recovery-focused community activities, e.g., recovery newsletter for people in medication-assisted recovery.<br>• Developing a Consumer's Guide to Medication-assisted Treatment & Recovery. |
| Support development of an inclusive, "non-denominational" (not linked to a single treatment or recovery mutual aid resource) culture of recovery. | • Ensuring diversity of pathways and styles of recovery in all structures (e.g., advisory groups, event planning groups) and activities.<br>• Encouraging development of recovery-focused activities in art, music, theatre, sports, and leisure. |
| Raise recovery consciousness at the community level. | • Creating task forces to address social and professional stigma attached to treatment and recovery.<br>• Hosting meet and greet meetings between recovery community organization leaders and local social/political/business/religious/media leaders.<br>• Involving community leaders and leading community institutions in recovery-focused public events.<br>• Promoting recovery-related stories through mainstream media channels.<br>• Challenging any media story that contains misinformation about addiction and recovery or that objectifies or stigmatizes people in recovery from alcohol and other drug problems.<br>• Using recovery mural and poster projects to elevate hope for and visibility of recovery in the community.<br>• Conducting and publicly disseminating results of recovery prevalence surveys (imbedded within existing public health surveys). |
| Build pathways of community reintegration for people with the most severe, complex, and enduring AOD problems. | • Strengthening linkages between addiction treatment and recovery community organizations and local educational and employment resources.<br>• Conducting skill training programs within the community recovery center. |

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| | • Operating a job bank within the community recovery center for people in recovery seeking employment.<br>• Encouraging people in recovery to hire and mentor people in recovery.<br>• Creating special recovery support programs for people re-entering the community from prison. |
| Integrate primary prevention (PP), early intervention (EI), treatment (Tx), and recovery support (RS) programs. | • Developing conceptual models for PP, EI, Tx, & RS integration.<br>• Ensuring inclusion of children and adolescent services representatives and prevention specialists in all governance and advisory bodies.<br>• Integrating discussions of PP/EI strategies for children of parents in treatment into treatment and post-treatment recovery education. |
| Increase the readiness of the broader health and human services network to embrace and integrate recovery support services. | • Training providers to enhance organizational readiness for integrating peer-based recovery support services (P-BRSS).<br>• Educating and training primary care providers on RM and the potential roles and benefits of P-BRSS.<br>• Advocating for the inclusion of SUD and related services to be a part of any community-wide health reform initiatives.<br>• Implementing demonstration projects that highlight the potential impact and relevance of RM approaches within other social services and healthcare arenas, e.g., child welfare and criminal justice systems. |

Those wishing additional information are encouraged to explore the following resources.

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## "I wanted a new beginning" Innovations in Recovery Management for People Experiencing Prolonged Homelessness in the City of Philadelphia

**Marcella Maguire, Timothy Sheahan and William White**

### Abstract

Substance use disorders and related conditions play significant roles in urban homelessness and its personal and social costs. Traditional addiction treatment programs have failed to attract, engage, retain, and effectively treat this population, leaving homeless persons excluded from addiction treatment or constituting a chronically recycling segment of the treatment population. This paper describes the design and outcomes of the Journey of Hope Project—a special homeless initiative that was part of a broader "recovery-focused systems transformation process" in the city of Philadelphia. New approaches to outreach, treatment, and continuing recovery management demonstrated the ability to recruit, retain, and enhance long-term recovery outcomes for individuals with histories of severe substance use and related disorders and chronic homelessness. The service designs described and the service outcomes reported underscore the need to radically alter traditional service models to achieve enhanced long-term recovery outcomes with this population.

## Assessment of Recovery Capital

*Please tick if you agree with any of the following statements*

1. Having a sense of purpose in life is important to my recovery journey ☐
2. I am able to concentrate when I need to ☐
3. I am actively involved in leisure and sport activities ☐
4. I am coping with the stresses in my life ☐
5. I am currently completely sober ☐
6. I am free from worries about money ☐
7. I am actively engaged in efforts to improve myself (training, education and/or self-awareness) ☐
8. I am happy dealing with a range of professional people ☐
9. I am happy with my personal life ☐
10. I am making good progress on my recovery journey ☐
11. I am proud of my home ☐
12. I am proud of the community I live in and feel a part of it ☐
13. I am satisfied with my involvement with my family ☐
14. I cope well with everyday tasks ☐
15. I do not let other people down ☐
16. I am free of threat or harm when I am at home ☐
17. I am happy with my appearance ☐
18. I engage in activities and events that support my recovery ☐
19. I eat regularly and have a balanced diet ☐
20. I engage in activities that I find enjoyable and fulfilling ☐
21. I feel physically well enough to work ☐
22. I feel safe and protected where I live ☐
23. I feel that I am in control of my substance use ☐
24. I feel that I am free to shape my own destiny ☐
25. I get lots of support from friends ☐
26. I get the emotional help and support I need from my family ☐
27. I have a special person that I can share my joys and sorrows with ☐
28. I have access to opportunities for career development (job opportunities,

volunteering or apprenticeships) ☐

29. I have enough energy to complete the tasks I set myself ☐
30. I have had no 'near things' about relapsing ☐
31. I have had no recent periods of substance intoxication ☐
32. I have no problems getting around ☐
33. I have the personal resources I need to make decisions about my future ☐
34. I have the privacy I need ☐
35. I look after my health and wellbeing ☐
36. I make sure I do nothing that hurts or damages other people ☐
37. I meet all my obligations promptly ☐
38. I regard my life as challenging and fulfilling without the needs for using drugs or alcohol ☐
39. I sleep well most nights ☐
40. I take full responsibility for my actions ☐
41. It is important for me to be involved in activities that contribute to my community ☐
42. In general I am satisfied with my life ☐
43. It is important for me to do what I can to help other people ☐
44. It is important to me that I make a contribution to society ☐
45. My living space has helped to drive my recovery journey ☐
46. My personal identity does not revolve around drug use or drinking ☐
47. There are more important things to me in life than using substances ☐
48. What happens to me in the future mostly depends on me ☐
49. I have a network of people I can rely on to support my recovery ☐
50. When I think of the future I feel optimistic ☐

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## Recovery-oriented Systems of Care: Reflections on the Meaning of a Widely Used Phrase

**Arthur C. Evans, Jr., PhD and William L. White, MA**

Since the late 1990s, the authors have been involved in numerous efforts to transform acute and palliative care models of addiction and mental health treatment into models of sustained recovery management (RM) nested within larger recovery-oriented systems of care (ROSC). Through that process, "RM" and "ROSC" have become code for a wide variety of behavioral health system transformation efforts. In this short essay, we would like to share with our readers what we mean when we talk about ROSC as an organizing concept for behavioral health care.

### Recovery

For us, recovery has three potential meanings. The first is the movement from a state of illness and isolation to a state of health and connectedness. In the addictions arena, this end state has been recently defined in terms of sobriety, improvement in global health, and citizenship. In the mental health arena, recovery has been described in terms of medical/clinical recovery (no longer meeting diagnostic criteria of active illness) and functional recovery (a socially connected and meaningful life in the community). Many people who have suffered severe behavioral health disorders achieve such full remission, with "recovery" depicting the process through which hope and health have been initiated and sustained.

A second meaning of recovery is the process through which one actively manages and transcends the symptoms of persistent illness to achieve improved quality of life and functioning. This means that some symptoms of the illness may continue to ebb and flow (e.g., cravings, obsessive thoughts, emotional distress), but they cease being the controlling center of one's personal, family, and social life.

For historically traumatized and oppressed populations, recovery may also involve drawing upon the historical resilience of a people and the assertion of personal and family health as an act of political resistance or cultural survival.

We see in these patterns of recovery quite different styles of personal relationship to illness: escaping illness, making peace with illness, and doing battle with illness. When recovery advocacy leaders proclaim that "there are multiple pathways of long-term recovery and all are cause for

celebration," they widen the ROSC tent to include all styles of personal recovery management and commit ROSC resources to support these myriad styles of recovery.

**Recovery-oriented**

"Recovery-oriented" within the context of ROSC means that system resources are strategically allocated toward this vision of recovery and whole health. 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 core knowledge driving service system design is based on the study of resilience and recovery rather than solely on the study of pathology or clinical interventions. 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, organizational budgets) have virtually no meaning and value unless linked to measurable, sustainable long-term recovery outcomes.

**System(s)**

The "system" in ROSC is first and foremost not a treatment provider or even a network of formal treatment providers. Instead, the "system" is a larger mobilization of recovery supports within a neighborhood, community, state, or nation. RM is a philosophical framework for organizing behavioral healthcare services; ROSC is a framework for creating the physical, psychological, and social space in the larger community ecosystem where recovery can flourish. While treatment providers can serve as a catalyst in mobilizing a ROSC, they cannot themselves be a ROSC. The ultimate goal of a ROSC is not an ever-expanding professional services system. While professional services are an important component of any ROSC, such services do not in and of themselves constitute an ROSC. A purported ROSC consisting only of recovery support available within funded agencies would violate the very meaning of a ROSC.

**Of Care**

The "care" in ROSC has multiple meanings. First, it reflects but transforms the concepts of "level of care" and "continuum of care." These latter phrases traditionally refer to the intensities and elements of formal health and human services. Care as services in ROSC shift from a focus on *intensity* of services to a vision of *extensity* of services. Recovery-oriented care means that the focus of support spans all stages of long-term recovery and not just the stage of recovery initiation and stabilization. ROSC resources are also directed to support pre-recovery priming, the transition from recovery initiation to recovery maintenance, enhanced quality of personal and family life in long-term recovery, and efforts to break intergenerational cycles of problem transmission. It is in extending its focus across these stages that the ROSC concept theoretically and in practice connects professional treatment and recovery support to indigenous recovery support systems and to the arenas of primary prevention, early intervention, and broader public health initiatives, including harm reduction.

Second, the meaning of care is extended beyond professional services to the creation of a healing community. Professionally directed services that aid the recovery process may be important components of this experience of community, but they are seen as secondary to the long-term importance of connection to community within the recovery experience. ROSC extends the acute care focus on an individual's thoughts, feelings, and behaviors to create a family and social milieu in which recovery can be ignited and sustained. The caring actor thus shifts from that of a paid professional to the family, extended family, community, and culture.

Third, the "care" in ROSC is a relational construct. "Care" becomes, in addition to a range of services and supports,

- an expression of empathy and compassion ("We share with you the experience of personal aspirations in the face of limitation and struggle."),
- a communication of invitation and acceptance ("Please join us. You are part of our communal family and our fates are inextricably linked."),
- a communication of value and affection ("We care about you and your future."),
- a communication of commitment ("We are committed to sustaining support to you in the days, months, and years to come."), and
- an expectation of responsibility and service ("Join us in this helping process: you now have a responsibility to 'pass it on'--help others and to help the community.").

Collectively, these communications serve to break the traditions of contempt, condemnation, and punishment that have so often plagued relationships between communities (and their representatives, e.g., service professionals) and persons with severe behavioral health disorders. A ROSC is as much a change of emotional affect within a community and culture as it is a change in professional service design and delivery.

**Summary**

Creating recovery-oriented systems of care involves a radical re-orientation of approaches to the long-term resolution of mental health and substance use disorders. The ROSC vision is more focused on personal possibilities than pathologies and more focused on continuity of long-term support in natural community relationships than the intensity of short-term professional interventions. Professional interventions can play crucial roles as aids to personal and family recovery, but such services are not a substitute for community relationships that are natural, continually accessible, reciprocal, enduring, and non-commercialized. ROSC is an approach to expanding and integrating these diverse forms of helping. The ultimate measure of ROSC is not the size and scope of professional services but a community's capacity for compassion, support, and inclusion.

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## The Society of Community Research and Action – Community Psychology, Division 27 of the American Psychological Association

## Policy Statement
## The Role of Recovery Residences in Promoting Long-term Addiction Recovery

### Executive Summary

Addiction and the larger arena of alcohol and other drug (AOD) abuse and related problems exact an enormous toll on individuals, families, organizations, local neighborhoods, and whole communities in the United States. Although a great number of advances have been made in AOD treatment, far too few individuals who could benefit from treatment receive it, and many who do receive treatment will resume AOD use following their discharge from it. New recovery support institutions are emerging beyond the arenas of traditional addiction treatment to support individuals hoping to initiate and to sustain long-term recovery from addiction. One promising mechanism is the recovery residence.

Recovery residences (e.g., sober living houses, recovery homes, and Oxford Houses™) are sober, safe, and healthy living environments that promote recovery from AOD use and associated problems. At a minimum, recovery residences offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence-based, long-term recovery. Recovery residences are sober living environments, meaning that residents are expected to abstain from alcohol and illegal drug use. Each credentialed recovery residence publishes policies on relapse sanctions and readmission criteria and other rules governing group living. Recovery residences may require abstinence from particular types of medications according to individual policy. Although the exact number is currently unknown, many thousands exist in the United States.

A small but growing body of research supports the effectiveness of recovery residences in sustaining abstinence and promoting gains in a variety of other domains, and the National Association of Recovery Residences has developed guidelines to define levels of care and standards to ensure the quality of care received. Yet, despite these advances, recovery residences face innumerable challenges. Critical questions regarding the operations and effects of recovery residence participation remain unanswered, and research scientists wishing to study

recovery residences face considerable funding challenges given the prevailing funding emphasis on the neuroscience of addiction. Efforts to establish or relocate recovery residences face challenges with start-up funding and often face considerable neighborhood and political opposition. Also of importance, many health and human professionals are unaware of recovery residences and their benefits on long-term recovery outcomes.

The Society of Community Research and Action (SCRA) has developed, with the executive, advocacy and research committees of the National Association of Recovery Residences (NARR), a policy statement on the value of recovery residences in the United States. This policy statement 1) describes the emergence and rapid growth of recovery residences as a new addiction recovery support institution, 2) highlights research to date on the positive effects of participation in a recovery residence on long-term addiction recovery and related outcomes, 3) champions a research agenda that would address many unanswered questions related to such participation, 4) advocates social policies (laws, regulations and funding guidelines) in which recovery residences can flourish, 5) supports programs of education and training to increase referrals to these new resources by health and human service professionals, and 6) promotes programs to educate local political leaders and the public about the value of recovery residences for individuals, families, and communities in the United States.

## Background

Addiction and the larger arena of alcohol and other drug (AOD) and related problems exact an enormous toll on individuals, families, organizations, local neighborhoods and whole communities in the United States. Since the mid-twentieth century, an elaborate network of professionally-directed addiction treatment programs has been funded to respond to these problems, but more than half of individuals treated in these institutions will resume AOD use following their discharge from treatment—most often in the first 90 days following discharge. Assertive continuing care and support is not a routine component of addiction treatment in the United States and only a small percentage of persons treated participate in post-treatment continuing care, which involves post-treatment monitoring and support. There are growing calls to shift acute care models of addiction treatment to models that emphasize sustained, post-treatment recovery management in order to elevate *long-term* recovery rates and enhance the quality of personal and family life in long-term recovery. Recovery management is a philosophical framework for organizing addiction treatment services to provide long-term recovery maintenance and quality-of-life enhancement for individuals and families affected by severe substance use disorders.

New recovery support institutions are emerging beyond the arenas of addiction treatment and recovery mutual aid societies to achieve these goals. By providing a physical and social world to recover within, these new institutions (e.g., recovery residences, recovery schools, recovery industries, recovery ministries, recovery community centers, recovery cafes, etc.), mark a major milestone in the history of recovery in the United States. One of the earliest to develop and one of the most important of these new institutions is the recovery residence.

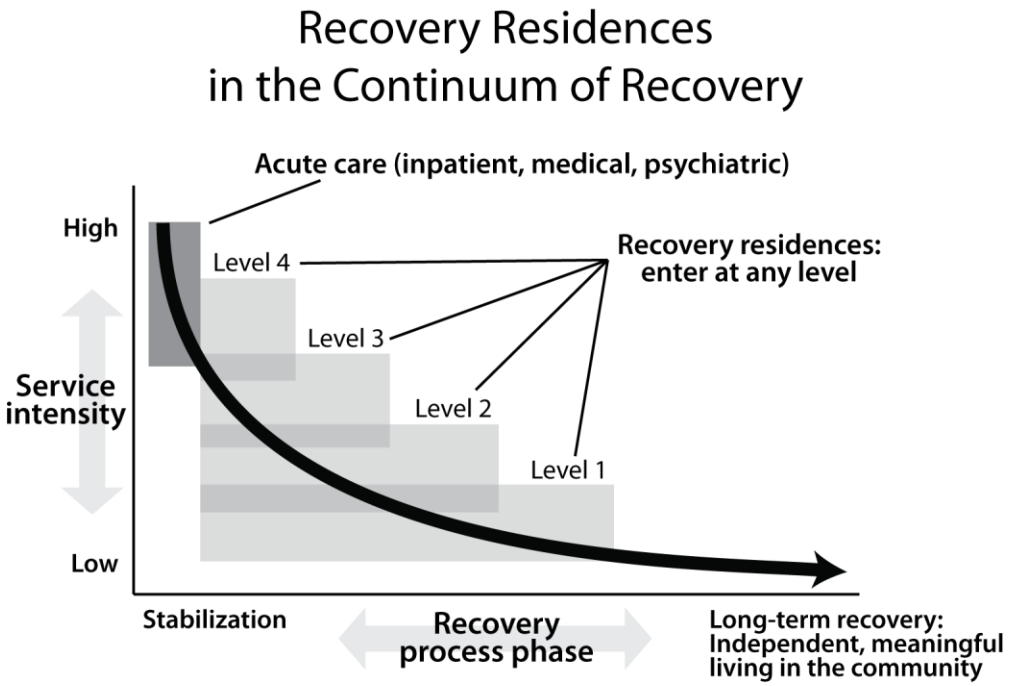
Recovery residences (e.g., sober living houses, recovery homes, and Oxford Houses™) are sober, safe, and healthy living environments that promote recovery from AOD use and associated problems. The number of recovery residences in the U.S. has grown dramatically in the past 25 years and have helped fill the void of community support between professionally-directed addiction treatment and peer-led recovery mutual aid societies. The purpose of a recovery residence is to provide a safe and healthy living environment to initiate and sustain recovery—defined as abstinence from alcohol and other non-prescribed drug use and improvement in one's physical, mental, spiritual, and social wellbeing. Individuals build

resources while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community. Although recovery is commonly believed to refer to abstinence and a general sense of quality of life, recovery is by no means a simple construct that has uniform definition (i.e., some individuals define it as abstinence only from their primary drug; or as use of alcohol, but no drugs; or as no use of “hard drugs” but use of marijuana, or allow for use of “medical marijuana.”)

There is growing consensus that recovery from severe substance use disorders involves three critical components: sobriety, improvement in global (physical, emotional, relational, spiritual) health, and citizenship (positive community reintegration). Recovery residences are abstinence-based environments that provide mutual support for these three elements of recovery -in contrast to "wet housing" that allows residents to use alcohol or other drugs or "damp housing" that discourages but does not exclude persons for using and that do not address these larger recovery processes.

A recent publication, *A Primer on Recovery Residences in the United States (*Jason, Mericle, Polcin, White, & the National Association of Recovery Residences, 2012), released by the National Association of Recovery Residences based on a review of all materials published on recovery residences to date found that:

- Although the exact number of recovery residences is currently unknown, there are many thousands of such residences operating in nearly every state across the nation;
- Recovery residences in the U.S. span from low to high service intensity and meet the needs of residents at various stages of recovery (see figure below):




- Most individuals in recovery residences have past or current involvement in addiction treatment and participate in 12-Step or other recovery mutual aid organizations during their time in the recovery residence.
- Participation in a recovery residence decreases in-treatment and post-treatment relapse rates and significantly increases recovery outcomes (using such recovery measures as sustained abstinence rates, improvements in global health and social functioning—e.g.,

high rates of employment) at up to two-years of follow-up. Longer-term (5-10 years) follow-up studies have not yet been conducted.
- These benefits extend to women, women with children, African-Americans, and persons with co-occurring psychiatric diagnoses.
- These benefits are contingent on adequate lengths of stay (more than 6 months in level I recovery residences) and a supportive community environment.
- The cost-effectiveness of recovery residences has not yet been rigorously investigated. However, some recovery residences, such as Oxford and California Sober Living Houses, are self-financed primarily through resident fees.
- Research to date generally finds that recovery residences do not negatively affect neighborhoods and may even provide benefits to the communities in which they are located.

Some recovery residences are designed specifically for individuals with certain needs (e.g., co-occurring addiction and severe mental illness, veterans, mothers with children); however, some recovery residences may not be equipped to adequately meet these residents' needs. Individuals with specific service needs seeking recovery residences should ask the provider about how these needs can (or cannot) be addressed within a particular residence. It is still unclear if outcomes differ for people with co-occurring disorders (mental health, process addictions, major medical issues such as Hepatitis C or HIV) living in recovery residences.

Recovery residences are divided into Levels of Support based on the type as well as the intensity and duration of support that they offer. Services provided span from peer-to-peer recovery support (all recovery residences) to medical and counseling services (recovery residences offering higher levels of support). The National Association of Recovery Residence Standards defines minimum services for each Level of Support, but additional services may be provided at each level. Section 5 of the National Association of Recovery Residences Standards, included in *A Primer on Recovery Residences in the United States,* details the minimum required service elements for each Level of Support. National Association of Recovery Residence-certified recovery residences meet standards addressing safety from an administrative, operational, property, and good neighbors' perspective. Recovery residences' internal governance varies across National Association of Recovery Residence Levels of Support. Forms of governance range from democratically run by the residents to oversight by licensed professionals. The regulation of recovery residences vary from state to state, local government to local government, and model to model. In general, states regulate professional services and local governments regulate health and safety standards. Both state and local government regulation must adhere to federal laws and limits, such as the Americans with Disabilities Act and the Fair Housing Act.

The National Association of Recovery Residences, established in 2011, currently represents approximately 1,500 residences through its local organizational affiliates. The National Association of Recovery Residences advocates for recovery residences and their residents at the national and local levels. Members of the National Association of Recovery Residence maintain standards for recovery residences of all kinds across the four National Association of Recovery Residence Levels of Support, from Level 1 peer-operated residences to Level 4 residences offering a wide variety of treatment and recovery support services. Three additional recovery residence organizations exist with a national scope. The oldest is the Association of Halfway House Alcoholism Programs, founded in 1958, and all are now affiliated with the National Association of Recovery Residences. The members of the Association of Halfway House Alcoholism Program include all of the National Association of Recovery Residences Levels of Support. The Association of Halfway House Alcoholism Program's residences operate in accordance with social model recovery principles. Oxford House Inc. was established in 1975

and supports Oxford Houses internationally. Oxford Houses are National Association of Recovery Residence Level 1, with each residence operated solely by the residents in accordance with Oxford House guidelines. Oxford House Inc. supports and promotes its model for peer-operated recovery residences through training, technical assistance, and access to startup financing. They also advocate for recovery housing rights and provide legal support to Oxford Houses involved in disputes with cities and towns over their right to exist. Treatment Communities of America (formerly Therapeutic Communities of America) represents more than 600 residential addiction treatment programs in the United States.

Recovery residences face innumerable challenges in spite of their rapid growth and positive findings on their effects on recovery outcomes. Critical questions regarding the operations and effects of recovery residence participation remain unanswered, and research scientists wishing to study recovery residences face considerable funding challenges given the prevailing funding emphasis on the neuroscience of addiction. Efforts to establish or relocate recovery residences face challenges with start-up funding and often face considerable neighborhood and political opposition. Also of importance, many health and human professionals are unaware of recovery residences and their benefits on long-term recovery outcomes.

**Recommendations**

In light of these findings and circumstances, the Society of Community Research and Action (SCRA):

1) Recommends that national, state, and local agencies support local networks of recovery residences. Specially, the SCRA calls upon:
    - The Substance Abuse and Mental Health Services Administration to develop funding mechanisms to support the development, sustainment, and expansion of recovery support services specific to housing.
    - The Department of Housing and Urban Development to develop funding mechanisms to support the development, sustainment, and expansion of housing services specifically for individuals in recovery from behavioral health disorders.
    - The National Association of Recovery Residences to disseminate national standards for recovery residences and to provide technical assistance for local organizations to meet these standards as a means of improving the quality of local recovery residences in the United States. This is of particular importance in order to deal with a perception by some that relapse is common among residents in recovery homes, they are often in unsafe neighborhoods, and many are disorganized and even exploitive of residents.
    - Single State Authorities on alcohol and other drug problems to establish loan funds and other mechanisms that will support the development of recovery residences where the need for such resources has been established.
    - The National Conference of State Legislatures, the United State Conference of Mayors, and the National League of Cities to develop policy documents and host webinars and conferences related to the issues surrounding the development of supportive housing for recovering individuals in local communities.

2) Recommends enhanced funding for critical research related to recovery residences. The SCRA calls upon:
    - The National Institutes of Health (the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse) to fund research related to recovery residences, including randomized clinical trials, long term outcome

studies, cost-effectiveness studies, and studies that isolate the most potent ingredients of the recovery residence model of recovery support. We need recovery outcome and cost savings data across the Levels of Support for various populations (including co-occurring, re-entry with criminal mindsets, etc.) recovering from a diversity of chemical substances in comparison to or in combination with alternative approaches. Without published research and evidence-based practice designations, licensed professionals and policymakers will continue to question the legitimacy of recovery residences and peer-based recovery.

- The Substance Abuse and Mental Health Administration's Center for Substance Abuse Treatment to fund evaluations studies related to the integration of recovery residences and related recovery support institutions (e.g., recovery community centers, recovery schools, recovery industries, recovery ministries) within the network of health care initiatives being launched by state and federal government.
    - Federal, state, and local funding sources to prioritize recovery residence research studies that address 1) the effects of participation in a recovery residence on treatment retention/completion and post-treatment relapse and recovery rates as well as measures of global health and social functioning—e.g., high rates of employment) at longer-term (5-10 years) intervals, 2) the degree of benefits living within recovery residences extends to women, women with children, African-Americans, and persons with co-occurring psychiatric diagnoses, 3) the degree to which benefits are contingent on adequate lengths of stay (more than 6 months in level I recovery residences) and a supportive community environment, 4) the relative cost-effectiveness of recovery residences, and 5) the effects of recovery residences on neighborhoods and communities in which they are located. These are all high priority areas for research that is needed to develop a more solid basis for our understanding of recovery residences and their impacts on residents and communities.
- National Association of Recovery Residences to increase their presence at key national conferences (National Association of Addiction Treatment Providers, the American Society of Addiction Medicine, and the American Association for the Treatment of Opioid Dependence) to engage the research community on the need for research on recovery residences.
- Editors of addiction-related professional and trade journals to continue to publish studies and reviews and special issues on the effects of participation in a recovery residence on long-term recovery outcomes.

3) Recommends strategies to educate and train addiction treatment professionals and allied health and human services professionals on the value of recovery homes. The SCRA calls upon:
    - The APA to disseminate this policy document to all APA members as well as to other major related professional associations (e.g., the American Psychiatric Association, the National Association of Social Workers) with the recommendation that the latter develop and disseminate policy statements on recovery residences and related recovery support institutions.
    - College and university addiction studies programs, independent addiction counselor training programs, and educational and training programs for psychiatrists, psychologists, and social workers to integrate information on recovery residences within their respective curricula.

- The national network of Addiction Technology Transfer Centers to disseminate information on recovery residences, including assertive referral procedures that can be used to access such resources and how recovery residences can be integrated into a continuum of care supporting long-term personal and family recovery from substance use disorders.
- The major addiction professional certification bodies [including NAADAC: The Association of Addiction Professionals, the International Certification & Reciprocity Consortium (IC&RC), the American Board of Addiction Medicine, and state addictions counselor certification boards] to integrate questions related to recovery residences into certification exams and their respective continuing education programs.
- The American Society of Addiction Medicine to formally recognize recovery residences as a level of care within its Patient Placement Criteria.

4) Recommends public education strategies that will address the stigma and misconceptions often attached to recovery homes and their residents. The SCRA calls upon:
    - The National Association of Recovery Residences to develop a public education campaign on recovery residences aimed at state and local civic leaders and media representatives.
    - The National Association of Recovery Residences' regional and state recovery residence consortia to collaborate with such leading recovery advocacy organizations as Faces and Voices of Recovery to incorporate issues related to recovery housing within larger recovery advocacy and anti-stigma campaigns.
    - The Legal Action Center to develop a kit for local recovery residences on how to respond to NIMBY hysteria and discrimination related to recovery housing regulations and their enforcement.
    - The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of Recovery Residences co-develop a recovery residence press kit and a webinar that could be incorporated into SAMSHA's 2013 Recovery Month activities.

Having reviewed the available scientific evidence on recovery residences, we believe these actions will play a significant role in elevating long-term addiction recovery outcomes in the United States and contribute to the quality of life of individuals, families and communities throughout the country.

The proposed policy statement was written by the National Association of Recovery Residences (NARR) research committee and approved by the NARR executive committee before submission to the SCRA. The NARR research members include Leonard A. Jason, PhD, Director, Center for Community Research, DePaul University; Amy A. Mericle, PhD, Research Scientist, Treatment Research Institute; Douglas L. Polcin, EdD, Senior Scientist, Alcohol Research Group; and William L. White, MA, Senior Research Consultant, Chestnut Health Systems.

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**WHITE, W. (2014). GUEST BLOG: INTERVIEW WITH WILLIAM WHITE. RECOVERY RESEARCH INSTITUTE / HARVARD MEDICAL SCHOOL. ACCESSED DECEMBER 1, 2014 AT HTTP://WWW.RECOVERYANSWERS.ORG/BLOG/INTERVIEW-WITH-WILLIAM-L-WHITE/**

# INTERVIEW WITH WILLIAM L. WHITE



William L. White is an Emeritus Senior Research Consultant at Chestnut Health Systems / Lighthouse Institute and past-chair of the board of Recovery Communities United. Mr. White has a Master's degree in Addiction Studies and has worked full time in the addictions field since 1969 as a streetworker, counselor, clinical director, researcher and well-traveled trainer and consultant. He has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 17 books. His book, *Slaying the Dragon – The History of Addiction Treatment and Recovery in America,* received the McGovern Family Foundation Award for the best book on addiction recovery. Mr. White's sustained contributions to the field have been

acknowledged by awards from the National Association of Addiction Treatment Providers, the National Council on Alcoholism and Drug Dependence, NAADAC: The Association of Addiction Professionals, the American Society of Addiction Medicine, and the Native American Wellbriety Movement.

## In Slaying the Dragon: The History of Addiction Treatment and Recovery in America, you discuss on page 511 that "a science of addiction will have little relevance until it is accompanied by a science of recovery and a science of prevention." What types of steps do addiction researchers and funders need to make in order to shrink this "gap"?

This comment reflects my belief that addiction science for more than 150 years has been a pathology-obsessed science. We know far more about the problem of addiction than we do about addiction-related resistance, resilience, and recovery. What is needed is a fully developed recovery research agenda that explores the prevalence, pathways, stages, styles, and durability of long-term personal and family recovery, including research on how to best break intergenerational cycles of addiction and related problems. It's an embarrassment that at this late stage of the field's development, and after billions of dollars in research expenditures, we still do not have answers to some of the most basic questions that arise within the processes of personal and family recovery. The field's infatuation with the problem has left elucidation of the solution (resistance, resilience and recovery) as the field's missing link. The stakes in this are high at personal, family, and cultural levels. For example, I believe that our obsession with the neurobiology of addiction and public portrayal of addiction as a brain disease will actually result in increased stigma and discrimination until there are tandem communications about the

prevalence, processes and personal and social fruits of long-term recovery.

The current research paradigm assumes that solutions will be found within studies of addiction pathology—its prevalence, patterns, and neurobiological and developmental pathways. A complementary and yet to be fully tested paradigm would involve equal emphasis on the study of recovery solutions that already exist in the lives of millions of individuals, and then extracting principles and practices from those lived solutions that can be professionally applied and publicly disseminated. Our two national addiction research institutes-NIDA and NIAA-need to bring recovery advocates, clinical leaders and the research community to the table to formulate and implement a fully-developed recovery research agenda and to establish systems to transfer knowledge garnered from this agenda to people seeking and in recovery, to addiction treatment and allied professionals, and to the public.

## What do you think is the biggest accomplishment for the field of addiction and recovery to date?

Modern addiction treatment as a system of care achieved two things. Frist, it displaced the worst of the despicable interventions that historically preceded it, e.g., fraudulent boxed and bottled home cures, mandatory sterilization laws, “drunk tanks” in city and county jails, “foul cells” in community hospitals, prolonged institutionalization in psychiatric institutions, indiscriminate application of chem- and electroconvulsive “therapies,” prefrontal lobotomies, and toxic and potentially lethal drug therapies, to name a few of the worst. Second it diverted people with severe, complex, and chronic addictions from systems in which they had been shunned, extruded, and mistreated to a system of care designed specifically to address their needs. This new system of addiction treatment provided two equally critical elements to individuals and families affected by alcohol and other drug problems: A system free

from contempt and moral judgment, and a system committed to the treatment of addiction as a primary problem guided by a core base of knowledge and clinical technologies that distinguished it from other helping professions. That emerging system of care forged in the mid-twentieth century had many imperfections, but it far exceeded anything that preceded it both in its compassion and its clinical capabilities. While cultural and institutional ownership of alcohol and other drug problems continues to be contested, the basic federal/state/local and public/private partnerships that built a national network of specialized addiction treatment resources have been sustained as has access to specialized addiction treatment services. That survival for nearly half a century is itself a notable achievement.

## What would you say is the most important aspect of current treatment and support? Why is it so important?

Most people who experience alcohol and other drug problems resolve these problems on their own. Addiction treatment stands as a safety net for those individuals with the most severe, complex and prolonged of such problems—individuals with the highest levels of personal vulnerability and the lowest levels of personal, family, and social recovery capital. For the latter individuals, professionally-directed addiction treatment offers the assistance needed to initiate and sustain recovery when prior personal and mutual aid efforts have failed to sustain recovery stability. There are hundreds of thousands of individuals in long-term recovery today who would not have achieved such recoveries in earlier eras when such specialized treatment and a broad range of recovery supports were not available. That is a modern public health success story that should be widely celebrated.

## Why is continued care after detox so important for maintaining sustained remission and recovery? What types of programs are available?

There is one discovery at the heart of specialized support for addiction recovery. That lesson is that a brief period of abstinence or decelerated use does not in itself constitute a sustainable solution to addiction. In fact, such periods of respite are as apt to be a milestone in a prolonged addiction career as they are a milestone of entry into long-term addiction recovery. Individuals, families and professional helpers have too often mistaken such temporary flights into health as sustainable recovery. The beginning of wisdom in addiction recovery—at personal and professional levels—is the recognition that what is required to sustain recovery is quite different than what is required to initiate recovery. Medical or social detoxification programs—and brief treatment programs—can help initiate recovery more effectively and more safely than at any time in human history, but such brief stabilization does not on its own represent a sustainable achievement. It only addresses acute life-threatening medical crises and provides a window of opportunity for movement towards long-term recovery maintenance. What we know from research on the course of recovery is that the point of recovery stability (point at which risk for lifetime recurrence of a substance use disorder drops below 15%) is 5 years—the same remission stability point often noted for cancer survivors. What this means is that acute biopsychosocial stabilization needs to be followed, particularly for those with the most severe and complex addictions, by sustained professional, peer, and family support.

## Looking at where treatment has come from historically, what do you think the trajectory of addiction treatment is in the next 25 years?

I think we will progressively disentangle widely varying patterns of drug problems and the solutions most suitable for each pattern. For the most severe of such problems, I have described five stages of recovery: 1) precovery (a recovery incubation period that rises within active addiction), 2) recovery initiation and stabilization, 3) the transition to recovery maintenance within one's natural environment or a new family/social environment, 4) enhanced quality of personal and family life in long-term recovery, and 5) efforts to break intergenerational cycles of addiction and related problems. We currently do exceptional work on the second of these stages, but we reach people too late (far into their addiction careers), we abandon them too soon (long before the transition to recovery maintenance and other developmental tasks of recovery have been mastered), and we have no widely utilized technologies focused on enhancing the resilience of the children of those we serve. Over the next 25 years, we will become more effective at treating less severe forms of alcohol and other drug problems, and we will become much more effective in treating the most severe and complex of such disorders. Efforts in both areas are already well under way. We would transform the state of public health in America if we were as successful at supporting the other four stages of addiction recovery as we are in supporting recovery initiation and stabilization (stage 2).

I think another great breakthrough in the next 25 years will be finding exceptionally potent combinations and sequences of interventions that will dramatically improve long-term recovery outcomes. For example, right now advances in psychosocial recovery supports and advances in medication-supported recovery often exist in isolation and as warring ideological camps. I think the future lies in the integration of services once thought to be incompatible. The turning point in the history of AIDS was discovering that treatments used in isolation that did little to alter the AIDS mortality rate could, when uniquely combined and

sequenced, transform the trajectory of this disorder. I think the same thing is possible with recovery from addiction.

## What is the message that you would like the general public to learn about recovery?

Here is my top 10 list:

1. Addiction recovery in America is quite prevalent but, until recently, culturally invisible, with more than 23 million Americans and their families now reporting that they once personally experienced, but no longer experience, alcohol and or other drug-related problems.
2. There are multiple (secular, spiritual, and religious) pathways and styles of recovery and all are cause for celebration.
3. Addiction recovery is contagious: It can be interpersonally transmitted from people in recovery and their professional allies to people actively addicted.
4. At a community level, addiction recovery is spread by recovery carriers—people in recovery who make recovery infectious through the quality of their lives, their character, and their visible message of hope to others.
5. The density of recovery carriers within a community can be strategically increased, opening potentially new strategies for community outreach and long-term recovery support.
6. Communities can address problems of addiction, in part, by openly inviting and eliciting recovery commitments from its addicted citizens ("Recovery by any means necessary under any circumstances") and by providing local landscapes (the physical, psychological, and social spaces and the policy environment) in which recovery can flourish.
7. The creation of recovery landscapes—science-based professional care, recovery mutual aid organizations, recovery support institutions (recovery community centers/homes/schools/industries/ministries) and vibrant local recovery cultures—shift the focus of support from one of "recovering from" to one of "recovering to" a meaningful and contributing life in the community.
8. There are whole communities wounded by addiction and related problems that are in need of a collective, community-wide recovery process; people in recovery can play a key role in sparking and supporting this healing process.
9. Recovery can give back to individuals, families and communities a portion of the toll addiction has taken.
10. People who were once part of the problem can be culturally mobilized to become part of the solution.



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## Outreach Services and Recovery Management: The New Pathways Approach

William L. White, Eugenia Argires and Sabrina Thigpen

### Introduction

One of the distinctive features of the recovery-focused behavioral health systems transformation process in the City of Philadelphia has been the concerted effort to shorten addiction careers and extend recovery careers through programs of assertive community outreach. The purpose of this paper is to illustrate such efforts through a description of the outreach services provided through New Pathways and New Pathways for Women, community-based recovery support programs located in North Philadelphia. This paper provides an overview of outreach services at New Pathways, explores the philosophical foundations of these services and describes the delivery of these services from the perspective of those delivering and receiving these services. Our intended audience for this paper is addiction treatment program personnel and recovery support specialists working within recovery community organizations who are interested in expanding community-based outreach services. The sources drawn upon in this paper include excerpts from interviews conducted by the lead author with the New Pathways staff and service consumers.

### New Pathways

New Pathways and New Pathways for Women are two of four outreach programs operated by the Public Health Management Corporation (PHMC). The two other PHMC outreach service projects are the HIV/HCV Prevention Street Outreach Project and the Philadelphia Hepatitis Outreach Project. During Fiscal Year 2013 (July 2012-March 2013), these four programs collectively:

- Logged more than 21,391 street encounters by their respective outreach teams,
- Hosted more than 7,615 drop-in center visits,
- Conducted 278 HCV screenings and 216 HIV on-site rapid tests,
- Provided recovery support group meetings for more than 2,700 attendees,
- Linked more than 70 individuals to addiction treatment, and
- Linked more than 1 620 individuals to other health and social service resources.

The New Pathways Project is a community-based pre-treatment recovery

support program serving men and women seeking help with their drug- and alcohol-related problems. Utilizing an integrated street outreach, case management counseling and recovery support group meeting model, project staff engage with individuals in active addiction and partner with them to increase their readiness for substance abuse treatment; decrease or eliminate their use of substances; promote their access to treatment; and facilitate their sustained recovery by providing support to those returning to the community following treatment. Individuals who are not ready to enter treatment receive recovery-oriented culturally tailored support including referral to health care, mental health and social services. The project team, several of whom are bilingual in Spanish and English, includes street outreach specialists, case managers, researchers, and a corps of consumers called Pathfinders who are trained as peer outreach workers. This project is supported with funding from the Office of Addiction Services of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. New Pathways and New Pathways for Women collectively conduct about 14,000 street encounters per year through their outreach programs and enroll 300 people in more intensive services, 200 through New Pathways and 100 through New Pathways for Women.

New Pathways for Women is gender-specific, trauma-informed, community-based pre-treatment and HIV prevention program serving women seeking help with their drug and alcohol problems. Staff members conduct outreach services to identify and engage with substance-involved African American women who are at high risk for HIV infection and to enroll them into project services. These services include enhanced individual pre-treatment counseling/case management support services, group psycho-educational and peer support sessions, on-site rapid HIV testing, and, as requested, escort and referral to medical care, substance abuse treatment, and other support services.

This integrated service model promotes women's understanding of the links between their exposure to violence and victimization and their use of drugs. Staff partner with women to increase their readiness for substance abuse treatment, decrease or eliminate their use of substances, promote their access to treatment, and facilitate their sustained recovery by providing support to those returning to the community following treatment. Women who are not ready to enter treatment receive recovery-oriented woman-centered support including referral to health care, mental health and supportive social services. The project team includes a street outreach worker, case managers, a group facilitator, and researchers. This project is supported with funding from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration.

**New Pathways Core Values**

Eugenia Argires, Program Director at New Pathways, described the overall program philosophy at New Pathways.

> *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 with 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.*[1] *New Pathways and New Pathways for Women are built on a pillar of people's entitlement to access recovery support. Their entitlement is not the result of being mandated to come to us. There is no quid pro quo where getting your kids back or getting housing is contingent on coming to us. You are instead entitled to what we have to offer. That entitlement then operates within this relational model. We proceed at your pace, recognizing how experiences of violence and victimization shape one's capacity for trust. We start from a position of what happened to you rather than what's wrong with you, and we practice intentional hospitality in a space that is safe, clean and colorful.*[2]

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.*
- *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*

[1] Eugenia Argires, personal communication, March 11, 2013

[2] Eugenia Argires Interview, November 11, 2013.

*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*.[3]

## Organization of Outreach Services at New Pathways

Outreach services at New Pathways have been provided in recent years in two different formats—a volunteer format (Pathfinders) through which current and former service recipients volunteer to conduct community outreach and a format through which full or part-time staff deliver outreach services. At present, New Pathways has three full-time outreach workers and has just reinitiated its volunteer Pathfinders outreach program. The services themselves are delivered through three service components. First, there is the assertive community outreach and engagement that happens in group venues, e.g., outreach workers meeting with groups of men and women in church-sponsored food programs, shelters and other service settings. Second, there is the one-on-one, street level outreach that is concentrated in high drug-copping areas of the community. Third, there are the individual recovery support services and psych-educational support groups that are offered out of the New Pathways facilities. These are accessed on a drop-in or scheduled basis and utilize motivational interviewing within a case management model.

In the section below, we will describe some of the more detailed aspects of outreach services provided through New Pathways and New Pathways for women, drawing on excerpts from interviews conducted in November 2014 with those providing, supervising and receiving such services.

## Recruitment of Outreach Workers

> *I look for folks who can understand addiction within a whole person context—people who can understand the use of substances as an adaptation to suffering and as a means of survival. I look for people who don't blame or stigmatize and people who have a high level of self-awareness so that they are able to contain themselves and really listen rather than jumping in to fix the other person before even knowing them.* (Eugenia Argires)

> *With recruiting, we look for a connection. Most of the folks that we have now are in recovery themselves or are a child of a mother or father who is in recovery. We look for someone who's relatable to the community they'll be serving. They wouldn't necessarily have to be in recovery but there needs to be some kind of linkage to the recovery experience and to the community. We want someone who feels safe and*

[3] 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.

*comfortable going into the community and someone who is comfortable engaging people and sharing their life story and their experience. It's not really easy to meet someone and use your own story to engage others.* (Sabrina Thigpen)

**On Becoming an Outreach Worker**

*I found out about New Pathways through a friend that told me about the position. I was working with children previously providing academic support. I've been around drug and alcohol addiction my whole life and grew up in the city, so when I heard about the position, I felt like it was a natural role for me. That's how I came to know about New Pathways a year ago and how I got into the field.* (Kareem Brown)

*I started off coming to the Pathways as a person seeking recovery. As a result of what I got here, I went back to school at Lincoln Tech to get hours toward certification. I needed some hours so I started volunteering as a Pathfinder. Pathfinders is a group of peer support persons in recovery who volunteer to go out in the community along with the Outreach Specialists to engage people and pass out information on our program risk reduction information. When a full-time position opened up for an outreach worker, I applied and have been working here ever since. It felt like my recovery background and education made me a perfect candidate for outreach.* (Sherri Jackson)

*I first started working here as an Outreach Specialist in North Philadelphia as part of a NIDA (National Institute on Drug Abuse) project interviewing women at risk for HIV and AIDs. That was in 1991, and the position was supposed to last six months. And I have been here ever since.* (Sabrina Thigpen)

**Initial Training and Organization of Outreach Workers**

*For new outreach workers, we provide HIV and hepatitis training (testing, counseling, etc.) and Trauma 101. We provide an overview of the program, an overview of recovery-oriented system of care, twelve-step recovery resources and an orientation to harm reduction. We have folks coming from other programs talk to staff about what they do. Sabrina does all kinds of team meetings and team building activities. She just did an appreciation breakfast and surprised everyone with fried fish and grits that she had prepared. I also mandate staff to attend a lot of professional development and training events.* (Eugenia Argires)

*We start with safety training. Our outreach workers need to know how to be safe because we mistakenly believe that if we have grown up in the community that we work in that we will be okay and that's how we let our guard down in terms of safety. So, we do safety trainings. Our outreach workers also go through training on HIV testing and counseling. We also do training on when and how to approach people in our street outreach. Outreach workers have access to our own internal training and to trainings held in the community.* (Sabrina Thigpen)

**Structure of Supervision**

*We* (outreach workers and supervisor) *talk every, day and we have team meetings bi-weekly. We are constantly communicating. On Mondays, we set the weekly schedule and decide what areas of the city we are going to focus on in our outreach*

*efforts. It's really hard for just three people to cover the whole city so we target the highest risk areas.* (Sabrina Thigpen)

**On Branding and Outreach**

*We try to create a clear image in the community of who we are. We're not here to save you; we're here to provide you things you may need and to do so on your terms. We have our colors, our posters, our t-shirts and the little cards we pass out to everyone we contact on the streets about how to contact us. What we want is to imbed ourselves so deeply and so positively in the community that most people get to us by word-of-mouth. We believe everyone in our community is entitled to what we offer and we honor everyone's resilience and capacity to survive.* (Eugenia Argires)

**Supervision and Safety**

*I think this is something I fall short on. I ask them routinely about safety issues and they often roll their eyes and say, "Eugenia, I live here. I've been there. I get it." But I make sure they don't go anywhere alone. They almost always work in teams of three. And I insist that they trust their instincts: if you don't feel safe, leave. Our best protection is that we care for one another.* (Eugenia Argires)

*Once we establish ourselves, those we serve help take care of us out there. We're helping them and they're helping us. You know what happens now when we go into an area on a bad day? People will come up to us and say, "I think it's time for you to leave because stuff getting ready to go down here."* (Sherri Jackson)

**Role Clarity Issues**

*Clarifying roles between all of our staff and other professionals in the community is quite a dance because you want boundaries and people practicing within the boundaries of what they know and can do, but you also want enough boundary flexibility to respond to people's immediate needs. We try to create that through our sanctuary model—a trauma-informed, culturally relevant, and strengths-based framework.* (Eugenia Argires)

*So, the role of the outreach person is just to engage, it's to meet, strike up a conversation, and sort out, whether a person is ready for recovery or for services that will help them get ready. The role ends there because the outreach staff is not to feel that they have to do everything. They're like a walking message of hope and a connection to resource. That's it.* (Sabrina Thigpen)

**Recovery Support versus Clinical Model**

*What we do is more of a recovery support model as opposed to a clinical model. For example, our groups are not group therapy. They're psycho-educational support groups. But as Frederick Douglass said, "Education is emancipation." We really believe that. In our groups we help people make connections between their feelings, their experience of trauma and their addiction experience. To begin to make those connections is so powerful because it provides a pathway to self-forgiveness. Our job is to create the space in which that can happen.*
*It's in that space where hope blooms.* (Eugenia Argires)

*When a woman or a man walks into the center, it's not, "This is your client." That's not how it works. They're not clients here. We're all a family. If you decide that you want to talk to me, then you talk to me. No one case manager or outreach worker or anyone else has ownership of the people who come here.* (Sabrina Thigpen)

**Intergenerational Cycles of Addiction**

*I have seen addiction move from generation to generation in both my personal history and from my work. I come from a line of generational addiction and feel like the cycle was broken between my mother and myself. I see so much intergenerational addiction as an outreach worker, but I do believe this cycle can be broken. We just have to continue to be more diligent in going out in the field and reaching people as early in this process as possible. At some point, people come around. We just have to get to them sooner.* (Sherri Jackson)

*I consider myself a student of history. I was already aware of the changes in the drug use among the people. In the '60s and '70s, it was more heroin and the needle. Then it switched to crack and cocaine. Now we see more people popping pills and smoking weed. Each generation seems to have its drug of choice, but the severe drug problems often tend to remain within the same families across these generations.* (Kareem Brown)

**Typical Day in the Life of an Outreach Worker**

*On a typical day we might go to Mount Olive, this church down on Broad Street between Masters and Jefferson, to give our presentations and meet all kinds of different people. Later that day we may be talking to people on the streets or underneath the bridge. I try to get everyone to remember my name and to greet and engage people like I wish somebody would have done with me.* (Sherri Jackson)

*You have to stay on top of the scene. People keep moving and the scene keeps moving. For folks that are using drugs, you may find people in South Philadelphia who you end up seeing again in North Philadelphia or those from North Philadelphia, you may end up seeing them in West Philadelphia. I can remember years ago a street off Germantown Avenue where the whole block was IV drug users and crack users. All those buildings are either torn down or are being rebuilt as the problem at this extreme moved to other areas. As outreach workers, we have to follow the problem to where it is most concentrated and move our efforts as it moves. I can recall the first time that I ever went out in the field. I was under the assumption that, because I'm from the urban community, there was nothing that I could see that would shock me. Then I went out into the field and I found myself coming home shocked, overwhelmed and crying. Even though I was a part of the community, I wasn't a part of this experience within my community. It was so different. And yet we have come to be accepted and embraced by this underground community. At times, folks on the streets offer us more protection than we get from the police department. Those we serve are also our safety net while we are out there.* (Sabrina Thigpen)

*I was from the worst parts of the inner-city, but I was still shocked when I began as an outreach worker. I saw things that made me think, "Do people really live like this?" And*

*engaging many of these people requires extended effort and patience, with some days being very frustrating. You want to help people but you must understand that people are going to get clean on their schedule, not yours, and that you just have to keep pushing the information and encouragement. And you have to live with the inconsistencies while people are working this out. Sometimes people tell you that they are going to come and then they don't. We're doing this engagement with people who are living very chaotic lives.* (Kareem Brown)

**Choice Philosophy**

*I think the outreach message is different now than it was years ago. Years ago, when I first started doing outreach, it was more of a scare tactic. The message at the height of the AIDS epidemic was, "If you don't do something, you're gonna die." As years went on, we realized that that message wasn't effective and may have even been harmful because it contributed to folks thinking, "Well, I'm going to die anyway, I might as well keep doing what I'm doing until then." The message today is about choices; what we're about is choices. Today we can accept people who are not ready for recovery and still offer encouragement toward that step and let them know we will be here when they are ready. When I came aboard on New Pathways, it was really shocking to know that we had a program where you don't have to make that choice today. What is unique about our program is that you make the choice. No judge is forcing you to come. When you walk through these doors you do so voluntarily. And we have a thousand folks a month who are voluntarily walking through these doors. That is a strong message on how they feel about recovery and how they feel about our approach.* (Sabrina Thigpen)

*When we go out and do our presentation, we always promote that we're unique. It makes a huge difference to know you have the choice to come in when you feel like it and that your voice will be heard as well as your right to choose what you want. I let people know that we have this menu of help and that they get to choose the kind of help they want from us.* (Sherri Jackson)

**Perspectives of People Engaged through Outreach**

*Outreach pulled me in the door. I'm a recovering addict. I had relapsed and I was out there using and I seen a part of the street that I never saw before and I thought I'd seen everything. I was at the lowest of my points, but I didn't know I wanted to stop getting high. I knew I had a wife and children that I had left behind. I just wanted to commit suicide with drugs; I didn't feel anything. It was my contact with Kareem [outreach worker] that changed this. He told me I could get my wife and kids back. So, I really started listening. And then, I started participating in the groups and giving my input and listening to other people's input and I got a day clean. And I said, "I'm coming back." And I got another day clean. Then I got a week clean and I'm still coming back. And then I'm looking in the mirror and I'm like, "Ho, you are somebody again." But this is without knowing what was happening. Then I start hearing things about goals and how to attain certain goals. Kareem was giving us that and I was listening. A lot of things was coming back to me. And then, I was calling home again. Then, I was going to see my children again. And now, I basically live back at home again. People out there were telling*

*me, "Man, it ain't gonna work. You ain't gonna do nothing but fall again." And I was like, no, I don't have to fall. Falling is a choice. And I'm looking at me today. My children are looking forward to me picking them up from daycare at 5:30. And I will be there.* (Male Participant)

*My name is Pam and I'm an addict. A young lady who used to come here gave me an invitation to come, but it took something to happen to me to get here. It was an abusive relationship. Once I came, you couldn't get me to leave. I struggle with my recovery but to this day, I'm clean and I'm focusing. I feel good. I can come here and I don't have to be ashamed. , Today, I give back of what was freely given to me. Right now, I'm going to school and I'm real grateful. I still suffer with a lot of aches and pains, but I still get here. I was initially staying clean just for my kids. Today, I just don't stay clean for my kids; I do it for myself.* (Female Participant)

**On Hitting Bottom and Hope**

*I believe everybody's process is different. The beauty of doing outreach is you come in contact with so many people and you might have this individual over here, she just tired of walking the street all night. She can go home, have the option to go home, to a beautiful home, but she decide to keep walking the street all night long, all night long. That's her bottom, though. And then, you have this individual over here that has to sleep on the street. Don't have nowhere to go but they're tired of being outside so now, I'm going to make a conscious decision to go into this program or go into this building and ask somebody help, so as far as that, the process is everybody's process and bottom is different. But what we've learned through outreach is that people can be reached before that bottom….Hope is the ultimate. Hope plays a major role in what we do and what those we serve experience to begin a recovery process. When you go out there, you have to know within yourself who you are and what you have to offer. And once you're confident with who you are and know what you have to offer, you pretty much can give any and everybody hope. You can take hope home with you. You can take it in the car. You can take it everywhere you go. I live on hope.* (Sherri Jackson)

*In the African-American community, hope comes from identification. When you meet someone who looks like you and has some of the same background as you who is now making it, it gives you hope. You know that if she did it, then maybe you can, too. When I'm sitting here talking to any woman that comes to New Pathways for Women, we're the same age. We have some of the same family backgrounds. We may have gone to the same school. I sit here and say to myself, "What happened to her? Why is she here and I'm where I am?" I've walked the road, too, so we have a common bond of understanding. That bond is the source of hope.* (Sabrina Thigpen)

*When people are addicted to drugs and alcohol, the mind is not always working in the best way so sometimes, the only thing you can do is affect the emotions and try to speak to that side of the person that gives them hope. That's what I aim at. It's hope that keeps drawing people back here.* (Kareem Brown)

*I remember this one class that Kareem did where he had "hope" written real big on the screen. Without the hope, I don't think anyone would continue to come. Once I felt hope*

*stirring in me, I started listening and making sense of some of the things that happened in my life. I ran from it through the use of drugs and that's why I'm where I'm at today. Hope helped me stop running.* (Male Participant)

**Spreading Recovery**

*I believe that recovery can be contagious. It's a trickle-down effect. I notice in the groups here that when the women are talking and having positive energy, they throw it on each other. They give each other that hope, they support each other.* (Sabrina Thigpen)

*There are a lot of people in recovery and they convey hope that can spread throughout the community. It's here. Anytime between five and six, you can go from Twenty-second in LeHigh all the way up to Twenty-ninth and its nothing but a recovery community. And you see it. You see the hope, you see the smiles, you see the laughter, and you can hear it in your car. You know what I do every day when I go up there? I'm going that way to pick up my granddaughter. I turn my radio down and I look out the window. Some days, I look so hard, I be right in the bumper, driving behind somebody's car. But I watch and I watch the movement and I look at the beauty. You know what's going on. Recovery is contagious. And it's contagious here at New Pathways.* (Sherri Jackson)

**Changing the Community**

*Addiction has broken the community and part of our job is to go out and help repair it. When you come out in greater numbers and show the community that we're serious about recovery, then things begin to change. We often give the example in group that, in certain neighborhoods, you couldn't stand on the corner for three minutes trying to sell drugs. They will run you out immediately because they got a collective community culture that makes that unacceptable. But in other cultures and communities, you can stand on the corner all day long and sell drugs. The whole community is involved in it because we are allowing all these things to go on. Part of our job is to help people stand up collectively and change the community culture.* (Kareem Brown)

*It's going to take us telling our children, teaching them, "You can make a better choice." I believe, as a recovering person myself, I have to instill this in my children, I always reiterate to them, "Life is about making choices. We can make this good choice over here, right, or you can make this choice. You don't want to make piss-poor choices like I did when I was your age"….If we could just pass that information along about recovery in the community, along with that nugget of hope, it'd be so contagious. You'd see a great change within the community. That's what we're trying to do.* (Sherri Jackson)

*That happens but you need more than what we have, we have just three outreach staff out in the community. We're just touching a small piece of what's in the pie.* (Sabrina Thigpen)

**Lessons for New Outreach Workers**

*Well, I think two things have helped me. Number one, I was raised seeing this problem so it's something that I want to solve. Secondly, I understand that we have to be doing something in the group that moves people toward goals they have identified. It we weren't moving toward goals and*

*seeing evidence that people were getting there, that would drain me. Progress in me and in those I work with is key to sustaining me.* (Kareem Brown)

*Know who you're talking to. Be consistent and stay consistent. People in need will look to you for trust. You have to be consistent to earn that trust.* (Kareem Brown)

*Be yourself. You can't go out in the street and be rigid. You gotta be relaxed, chilled out, chilled to the max. You have to go with the flow of what's going on out there. If you got twenty people over here and they're going hand-to-hand combat and we're down here underneath this bridge giving out condoms, we're paying attention to what's going on. We're looking at everything. We're looking at the five walking down the little hill. We're looking at the two coming in.* (Sherri Jackson)

*Well, I go to church. A lot of prayer helps. I stay linked with positive people. I have an awesome, awesome, awesome support system through my family and all the people here I work with. I can call Sabrina anytime I feel like it. I can call Eugenia anytime I feel like it. I can call Celeste. I can call anybody. Having a great support system helps. My own personal belief in my higher power keeps me involved in the positives. And I got a new grandbaby that keeps me super-busy.* (Sherri Jackson)

*Be patient and consistent. If you don't believe in your message, no one else will either. And you have to be honest and not let people put their stuff on you. I don't allow you to leave me at fault for what you're going to do or not going to do. I can't go home with that on my conscience or go home and sleep well knowing that, I just can't do it. So, we're going to discuss and you say to me, "I enjoy doing drugs and that's what I want to do. However, I don't really like being homeless." Well, then, we're going to sit and have a discussion. Do you think your homelessness is related to your drug use? Nine times out of ten, they'll say, 'yes.' Well, then, maybe we need to switch up how often you're doing drugs if you don't want to be homeless. But if you enjoy drugs and you enjoy being homeless and you're not hurting anyone else, then that's your choice.* (Sabrina Thigpen)

*For me, it's therapeutic when I sit in groups where we're sharing information. It's therapeutic for both of us. I give a lot but I also learn a lot. It's an exchange. And on my days off, I find time for myself and to be with my children and my new grandson. Finding time for yourself is important to keep doing what we do.* (Sabrina Thigpen)

*Well as a supervisor, you have to be patient and have an open mind. You have to do more listening than talking. Outreach teams are on the front line. Every day they go out, and never know what they're going to encounter. They should know that you're there for them. They need to feel safe going out and safe when they come back in. They need to be able to relieve some of the daily stressor of what they've seen, heard, or what they know, what's going on in the community. They need to be able to come back and drop that load on to their supervisor, that's really important. It gives me them more energy and it feels that what they're doing is worthwhile. I don't believe the outreach team is recognized for the good work. Some people feel outreach is not really effective, I believe different. I believe the outreach team is the most important*

*team in the public health arena because you're talking to men and women who may be at a pre-contemplation stage who're not thinking of treatment or thinking of recovery or thinking of just reducing whatever that high risk behavior is. We have the outreach team who's right there meeting you where you are at the right time to just have that open discussion with you. Many folks they encounter in the field will eventually come back to New Pathways and New Pathways for Women. However, that initial meeting started out with the outreach team building relationships. It's not that the community of people knew that New Pathways and New Pathways for Women is there, however they know there is an outreach team that's non-judgmental and will assist and provide them with every day public health needs..* (Sabrina Thigpen)

## Conclusions

The recovery-focused transformation process within the City of Philadelphia's behavioral healthcare system has included efforts to reach people at earlier stages of addiction, engage those individuals and support their processes of long-term recovery. The outreach programs at New Pathways exemplify this new assertive approach to outreach and engagement. In this paper, we have described the philosophy behind this approach and used the voices of key staff to explore various dimensions of the outreach process and the supervision of outreach workers. If there was a single theme that pervaded the interviews and focus groups upon which this paper is based, it is that people can be reached through messages of hope as well as the accumulation of addiction-related pain. If there is a single role the outreach worker plays, it is bringing that hope to the very doorstep of those most in need of this message.

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# Selected Papers of William L. White

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

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## Multiple Pathways and Styles of Addiction Recovery
## CCAR Multiple Pathways of Recovery Conference Keynote
## May 2, 2016
## Presentation Outline & References
## Title

**William L. White**
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**Self-Introduction**

- Epiphany in Dallas
- Toward a Recovery Paradigm
  --From pathogenic orientation (focus on causes, course, & consequences of addiction) to salutogenic orientation (focus on recovery, health & capacities for resilience)
- Presentation Goal: Outline common pathways and styles of addiction recovery (drawn from scientific/historical literature and collective recovery experience)

**Recovery Definition**

- Remission versus recovery
- Consensus on 3 dimensions of recovery, e.g., Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship. (Betty Ford Institute Consensus Panel, 2007)

**Remission/Recovery Prevalence**

- Rates of SUD remission in major U.S. epidemiological studies range from 5.3% to 15.3%.
- Those 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). (See White 2012 monograph)

- Recovery prevalence via 3-part definition yet to be determined

**Distinction between "Pathways to" and "Pathways of" Recovery**

- Archetypal three-part recovery story style: "what we used to be like, what happened, and what we are like now"
- *Pathways to* focuses on varying forms of destruction and residual debris of active addiction" that set stage for recovery, e,g., "what we used to be like"
- *Pathways of* focuses on variations in the catalytic process of recovery initiation and the varieties of recovery experience over the long-term course of recovery
- Distinction between *recovering from* (pathogenic focus) and *recovering to* (salutogenic focus)

**Recovery from what?**

- Recovery has meaning only in the context of illness (condition that meets diagnostic criteria)
- Other terms apply to sub-clinical AOD problems, e.g., resolve, quit, control, manage `

**Pathway and Style Differences across Populations**

- Age (e.g., adolescents and transition age youth, older adults)
- Gender
- Ethnicity, culture, and religion, e.g., concepts of *culturally-shaped addiction careers* and *cultural pathways of recovery*
- Sexual identity and orientation
- Co-occurring medical/psychiatric conditions
- Trauma (e.g., survivors of developmental trauma, war, historical trauma) --Research on traumagenic factors and healing sanctuaries)
- Concepts of *concurrent and serial recoveries*

**Recovery Rubrics**

- *Personal Recovery*
- *Family Recovery* (See Stephanie Brown Interview)
  --Family Subsystems
  --Vulnerability of family through stages of recovery (Brown's "Trauma of Recovery")
  --Need for *supportive scaffolding* during early recovery
  --Neglected constituency: "recovery" encompassing families grieving AOD-related loss of family member
- *Community Recovery*
- Parallel Processes across Personal/Family/Community Recovery
- Personal, family, and community *recovery capital*
- Recovery Resource Mapping across Pathways

**Changing Views on Role of Motivation in Recovery**

- Push forces (Pain) to Pull forces (Hope); not either/or but power of combinations
- Wide variations in "what happened" (turn-around) element of recovery story
- Push factors: Creating motivational fulcrums within family/community/culture

- Pull Factors*: Contagiousness of recovery & Role of Recovery Carriers*

**Temporal Frameworks of Recovery**

- *Stage-dependent Recovery*
  --Numerous stage models
- White: Precovery, Recovery Initiation, Recovery Maintenance, Enhanced Quality of Personal/family life in long-term recovery, Efforts to Break Intergenerational Cycles of Addiction
  --Question of how staged change differs across diverse populations
- *Transformative Change (TC)*
  --Recovery as conversion experience (defining moment, peak experience, epiphany) forever cleaving one's life into categories of "before" and "after"
  --Unplanned, positive, vivid, and permanent
  --TC experiences of recovery messiahs (e.g., Handsome Lake, Jerry McAuley, Bill Wilson, Malcolm X)

**Depth of Change in Recovery**

- 3 components of emerging recovery definitions in U.S. & U.K.: AOD problem resolution (as measured by clinical remission or sustained abstinence), enhanced global health/functioning, and positive change in person-community relationship
  --Researchers and HR advocates include moderated resolution of AOD problems within the recovery rubric, e.g., *moderated recovery* (sustained deceleration of AOD problems to subclinical levels)
- *Full Recovery* across 3 components
- *Partial Recovery*
  --Full achievement in one area but impairment continuing in other areas
  --Improvement but continuing impairment in one or more areas
- *Amplified Recovery* across 3 elements: Above-optimum levels of health and social contribution

**Organizing Frameworks of Addiction Recovery**

- Secular (SE)
- Spiritual (SP)
- Religious (RE)
- Mirroring of frameworks in U.S. Recovery Mutual Aid Organizations
  SE: e.g., Women for Sobriety, Secular Organizations for Sobriety, SMART Recovery, LifeRing Secular Recovery, Moderation Management
  SP: e.g., AA, NA, and other 12-Step Fellowships; Wellbriety Movement
  RE: e.g., Alcoholics Victorious, Celebrate Recovery, Millati Islami, Buddhist Recovery Network
- *Dual Citizenship* in recovery
  --Co-attendance across recovery fellowships
  --Varieties within recovery fellowships, e.g., from Back to Basics to Quad A and AA Agnostica within AA
- Potential for a *secular spirituality*
- Potential for changes in orientation across stages of recovery

**Commonly Shared Elements of Recovery Spirituality** (from Kurtz & White, 2014)

- Within (Intrapersonal)
- Between (Interpersonal)
- Beyond (Transpersonal)
- Kurtz's 6 Dimensions of Recovery Spirituality
  --Release
  --Gratitude
  --Humility
  --Tolerance
  --Forgiveness
  --Being-at-Home

**Pathways of Recovery Assistance**

- Natural Recovery Initiation and Maintenance
- Peer-assisted Recovery Initiation and Maintenance
  --Recovery mutual aid organizations
  --New recovery support institutions
  --New recovery support roles
- Professionally-Assisted Initiation and Maintenance
  --Non-specialty help
  --Specialized addiction treatment
  --Medication-assisted treatment/recovery (Subcategories can legitimize but also create recovery status hierarchies)
- Trends in Face-to-Face and Virtual Recovery Support
  --Expansion of Virtual communities of recovery
  --New Technologies of Recovery Support (SMART Phones and beyond)
  --Trend Projections

**Relational Styles in Recovery**

--Acultural
--Bicultural
--Culturally enmeshed
--Changes in styles across stages of recovery

**Identity Patterns in Recovery**

- Neutral Identity (Remission without recovery identity)
- Positive Identity (Recovery central part of personal identity)
- Negative Identity (Recovery Identity Closeted in shame)

**Multiple Pathways/Styles: Implications for Addiction Treatment**

- From addiction treatment experts to students of recovery
- Extending intrapersonal models of addiction/treatment/recovery to ecological models that include larger community and cultural interventions
- From "acute care" or "palliative care" models of service to models of *sustained recovery management* (RM) nested in larger *recovery-oriented systems of care* (ROSC), with "system" being, not the treatment system" but a larger mobilization of recovery supports within the community/culture

- From packaged “programs” to highly individualized service planning and delivery processes
- Emphasis on expansion of service menus and “philosophy of choice”
- Expansion of the service delivery team, e.g., inclusion of indigenous healers
- Post-treatment recovery checkups for at least 5 years (5-year recovery durability data)

**Multiple Pathways of Recovery within the New Recovery Advocacy Movement**

- “There are multiple pathways of recovery—and ALL are cause for celebration.”
- “Recovery by any means necessary under any circumstances.”
- From isolated and competing organizations to a larger embracing identity (people seeking and in long-term recovery) and an “ecumenical culture of recovery” that embraces and yet transcends these organizational identities
- CCAR’s “You are in recovery if you say you are.”
- Becoming culturally informed, fluent, competent, and connected across pathways/communities of recovery
- Forging *recovery space* (*recovery landscapes*) within local communities

**Closing**

- Recognition of multiple pathways of recovery will require that we address any potential “hardening of the categories” across the spectrum of addiction treatment and recovery support services
- *Authenticity of recovery representation* must include recovery pathway and style diversity
- We must all become students of recovery: stance of humility and learning from the experience of those we serve.
- The understanding of long-term recovery and its many pathways and styles constitutes the new frontier within the alcohol and other drug problems arena.
- I wish each of you godspeed on your journey into that future.

**Brief Bibliography (See 2015 Recovery Bibliography at www.williamwhitepapers.com)**


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# Selected Papers of William L. White

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**Citation**: Schuyler, A., Brown, J., & White, W. (2016). The Recovery Coach: ROLE CLARITY MATRIX Posted at **www.williamwhitepapers.com**

## The Recovery Coach: ROLE CLARITY MATRIX

Alida Schuyler MS, PCC; Jan Brown, BA, MRLC; William White, MA

A wide variety of specialized roles have evolved to assist individuals and families achieve recovery achieve recovery from addiction, including recovery from what have been called process addictions—harmful relationships with gambling, food, sex, money, etc. There is a long history of addiction medicine specialists (addiction-trained physicians, psychiatrists, physician assistants, nurse practitioners, nurses), addiction counselors, addiction-trained therapists, outreach workers, case managers, and interventionists, to name just a few. One of the most recently emerging roles is that of the *recovery coach*. This particular role has a complex etymology, with roots in both the voluntary peer supports found in addiction recovery mutual aid societies and in the field of professional life coaching. As a result of this mixed heritage, the public is now confronted with a variety of people calling themselves recovery coaches or offering recovery coaching as a specialized service who vary considerably in how they perceive and practice this role.

In 2011 and 2012, Alida Schuyler, Jan Brown, and Bill White began an extended dialogue (via phone conferences) on recovery coaching and the need for clearer definitions and standards governing this role. Alida drew from her roots in the professional coaching arena. Jan drew from her roots as a professional coach and her knowledge and experience from her work in the development of peer-based recovery support services within recovery community organizations and addiction treatment programs. Bill drew from his experience as an addictions counselor and his consultations and evaluations of peer-based recovery support services. What we began to explore was the differences between professional life coaches who had begun to specialize in working with individuals in addiction recovery, the professionalized role of addiction counseling, and peer recovery support specialists who were incorporating coaching into their helping processes. A *Role Clarity Matrix* was created to record our evolving meditations on these roles. Based on the increased requests the authors have received requesting information on recovery coaching, we decided to share our in-progress work on the *Matrix*, with full knowledge that these roles vary widely in how they are defined and performed across organizational and cultural contexts and with full knowledge that they continue to dynamically evolve. Our depictions of key differences in the roles of peer recovery coach, addiction counselor, and professional recovery coach are based on our best perception of how these respective roles are most frequently performed.

For the latest version or to offer comments or suggestions on the Matrix, please email Alida Schuyler at coachalida@gmail.com.

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| **Other Titles** | Peer, Peer Specialist, Recovery Support Specialist, Recovery Coach, Peer Mentor, | AOD Counselor, Chemical Dependency Counselor, Clinical Case Manager | Recovery Coach, Recovery Life Coach, Professional |

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| | Recovery Guide | | Coach, Life or Business Coach with expertise in addiction recovery |
| **Primary Purpose of Role** | Promotion of longterm addiction recovery, with *recovery* most frequently defined in terms of sobriety (or remission), enhancement of wellness and recovery capital, and healing of person-community relationship (citizenship) | Achievement of personal/family recovery with recovery defined in terms of post-treatment abstinence and social function and enhancement of family health; Healing and resolution of related traumas, issues, blocks | Personal transformation resulting in peace with past and others; present life in good order; imagining and working towards a powerful, positive, and compelling vision of future; manifestation of unique and satisfying life in recovery |

| | | | |
|---|---|---|---|
| **Nature of Role** | Non-clinical, recovery model, being integrated into behavioral health, emerged out of new grassroots recovery community organizations and expansion of recovery support services | Clinical, (medical & social models) emerged within the professionalization of addiction treatment and being encompassed within present integration of behavioral health | Non-clinical, nondiagnostic, supporting multiple pathways to recovery, rooted in strengths and wellness; successoriented, expansion of the personal coaching and business coaching models, focus is on personal transformation |
| **Relational Model** | Natural/Partnership reciprocal (nonhierarchical), noncommercialized, and potentially enduring | Professional, hierarchical, (expert model), highly commoditized and commercialized (as a billable service), transient (ever-briefer) | Partnership of equals co-created in service of the client: client is the expert on |

| | **Peer Recovery Support Specialist** | **Addiction Counselor** | **Professional Recovery Coach** |
|---|---|---|---|

| | | | |
|---|---|---|---|
| | Peer model based on lived experience and mutual support<br><br>Uses his/her own story as a means of offering testimony to the reality and power of recovery, uses his/her own story as guidance on how to live in recovery | Expert model teaching client/patient what he/she should or must do to recover; recent calls for transition from expert model to partnership model | themselves and at choice, coach brings expertise in communication, and as change agent<br><br>Business relationship and structure; collaborative, strengths-based; emphasis on supporting, challenging, and accountability; as brief or enduring as client & coach choose, typically a 3-month minimum—lasts as long as is useful—months or years |
| **Recovery Philosophy** | Natural/Partnership reciprocal (nonhierarchical), noncommercialized, and potentially enduring<br><br>Peer model based on lived experience and mutual support<br><br>Uses his/her own story as a means of offering testimony to the reality and power of recovery, uses his/her own story as guidance on how to live in recovery Recovery most often | Tend to view recovery as something that happens inside the client and focuses on breaking the person-drug relationship, modifying the client's perceptions, thoughts, and actions, and assessment of the environmental influences of addiction and recovery | View recovery as something that is naturally attractive and occurs when the client is in touch with the outcomes they want in their life and has ongoing support and accountability in their capacity to be successful |

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| | viewed as something that happens in one's relationship with oneself, God, family, and community; strong advocacy role to shape pro-recovery policies and practices in the community | | |
| **Support across the Stages of Recovery** | May include collaboration with addiction professionals on recovery initiation and extends beyond to include pre-recovery, transition between recovery initiation and recovery maintenance, transition from recovery maintenance to enhanced quality of life in long-term recovery | Primary focus in on recovery initiation/biopsychosocial stabilization of persons committed to sustained abstinence; recent calls to integrate harm reduction perspectives within the role; recent calls for sustained post-treatment recovery checkups | May work individually or as part of team, supporting multiple pathways to recovery across all stages from pre-recovery through longterm. Supports client's choice of where to begin, what to work on, and vision of desired outcomes |
| **Recovery Goals** | Focus on removing obstacles to recovery and building personal, family, and community recovery capital to support long- term recovery | Primary role is in facilitating the process of recovery initiation for those who have reached a point of readiness to change | Focus on facilitating selfunderstanding and a higher level of functioning & performance; helping client achieve their life, business, and recovery goals more easily and quickly than they would on their own; increasing internal and external skills and assets |
| **Recovery** | Facilitates the | Utilizes problems generated | Facilitates the |

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| **Planning Framework** | development of a person-driven recovery plan, much broader in scope and more community- and recovery-focused than traditional treatment plans | from the assessment data to generate a professionallydirected treatment plan; makes diagnosis; probes undisclosed “issues” | development of client-driven goals & plans based on their stated outcomes, and facilitates the skills needed to achieve them; broader than abstinence to include lifestyle and vision of success. |
| **Words Used to Describe the Activities of the Role** | Identify, engage, encourage, motivate, share, express, enhance, orient, help, link, consult, monitor, transport, praise, enlist, support, organize, advocate, empower, model | Diagnose, treat, assess, screen, refer, document, counsel, pathology, educate, advise | Coach, facilitate, converse, cocreate, partner, inspire, brainstorm, clarify, questioning consult, reframe, motivate, listen, reflect, challenge, accountability |
| **Education and Training** | Credibility springs from experiential knowledge (direct experience) and experiential expertise (demonstrated ability to use experiential knowledge to affect change in oneself and others), certification status for peer recovery support specialists varies widely by state | Credentialed by experience of formal education and institutionally credential led via certification or licensure, NAADAC, ICRC, state certification bodies | Coach training program, credentialing may occur through professional coaching organizations such as Recovery Coaches International (RCI), International Coaching Federation (ICF), International Association of Coaching (IAC), European Mentoring and |

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| | | | Coaching Council (EMCC), etc. |
| **Core Competence** | Knowledge of and modeling of core recovery competencies or values; pathways, styles and stages of personal & family recovery; knowledge of diverse cultures of recovery; ability to navigate service structures of local recovery mutual aid groups and recovery community organizations; skills in recovery planning; assertive linkage to indigenous recovery supports; capacity to navigate linkage to formal service systems | Includes knowledge of addiction and skills to perform clinically-oriented functions; pharmacology, epidemiology, theories of addiction; screening and assessment skills; theories of counseling; treatment planning cultural competence; counseling techniques, ethical decisionmaking; documentation protocol; working within multidisciplinary team | Includes knowledge and use of professional coaching skills, understanding or knowledge of recovery and addiction, and additional topics as needed with a given client; screening clients for ability to benefit from coaching; establishing client-driven goals for coaching; asking for permission before offering advice or resources; adapting to client's learning style and changing capacity; coaching to increase client's motivation and confidence; excellent skills in listening, questioning, and reflecting; ability to generate possibility and elicit positive change talk; supporting and |

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| | | | challenging; skill in setting goals, organizing and creating effective plans (including recovery plans), addressing health care issues including impact of addictions and behaviors on self, family, community |
| **Financial Payment** | May be volunteer or paid position | Paid position | Paid position with or without pro bono work |
| **Duration of Contact** | Highly variable, with some expected to sustain contact for months and years, longer service relationship, focus on maintaining continuity of contact over time | Relationship is characterized by a clear beginning, middle, and end; relatively brief and becoming ever briefer, posttreatment contact historically viewed as ethically suspect | Coaching relationship is maintained until goals are achieved or as long as the client wants or needs coaching (assuming that coaching is effective for them). This may last for months or years |
| **Service Delivery Area** | In the person's natural environment; linking people from treatment institutions to indigenous communities of recovery; support delivered as close as possible to the person's natural environment; telephone based and other e-based recovery supports | Treatment center or institution; office based; some extension to "etherapy" | Meets with client in person or by telephone; typically for international clients, meeting via Skype, phone, or email |

| | Peer Recovery Support Specialist | Addiction Counselor | Professional Recovery Coach |
|---|---|---|---|
| **Linkage to Local Communities of Recovery** | Direct communication with indigenous recovery support organizations<br><br>Emphasis on orienting and assertively guiding individuals into engagement with communities of recovery | Variable levels of communication with indigenous recovery community organizations<br><br>Passive referral (verbal encouragement with possible provision of meeting list) is dominant pattern; growing calls for more assertive linkage procedures | Minimal or indirect communication with indigenous recovery community organizations<br><br>Client is coached to find and connect with a broad spectrum of resources, including local or online communities of recovery<br><br>Useful for those areas with few services or for additional recovery pathway options |

**About the Authors**: Alida Schuyler MS, PCC, is a Professional Certified Coach, a Master Recovery

Life Coach, and an international expert on Recovery Life Coaching. She is the co-founder of Recovery Coaches International, and Director of Crossroads Recovery Coaching Inc., a training school for recovery life coaching. Jan Brown, BA, MRLC, a certified Professional Recovery Coach, is the founding and executive director for SpiritWorks Foundation Center for Recovery of the Soul, the Center for Addiction Recovery & Wellness. She served as a subject matter expert on the development of the International Credentialing and Reciprocity Consortium's (IC&RC) peer recovery credential. William White, MA, is Emeritus Senior Research Consultant at Chestnut Health Systems. He has served as a volunteer consultant to Faces and Voices of Recovery and is author of *Peer-based Addiction Recovery Support Services: History, Theory, Practice and Scientific Evaluation* and *The History of Addiction Counseling in the United States*.



# Selected Papers of William L. White

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## Development and Validation of a Brief Assessment of Recovery Capital (BARC-10) for Alcohol and Drug Use Disorder

**Abstract**

**Background**: It has been long established that achieving recovery from an alcohol or other drug use disorder is associated with increased biobehavioral stress. To enhance the chances of recovery, a variety of psychological, physical, social, and environmental resources, known as "recovery capital", are deemed important as they can help mitigate this high stress burden. A 50-item measure of recovery capital was developed (Assessment of Recovery Capital [ARC]), with 10 subscales; however, a briefer version could enhance further deployment in research and busy clinical/recovery support service settings. To help increase utility of the measure, the goal of the current study was to create a shorter version using Item Response Theory models. **Method**: Items were pooled from the original treatment samples from Scotland and Australia (*N*=450) for scale reduction. A reduced version was tested in an independent sample (*N*=123), and a Receiver Operating Characteristic Curve was constructed to determine optimal cut-off for sustained remission ($\geq$ 12 months abstinence). **Results**: An abbreviated 10-item measure of recovery capital captured item representation from all 10 original subscales, was invariant across participant's locality and gender, had high internal consistency (α = .90), concurrent validity with the original measure ($r_{pb}$ =.90), and predictive validity with sustained remission using a cut-off score of 47. **Conclusion**: The brief assessment of recovery capital 10-item version (BARC-10) concisely measures a single unified dimension of recovery capital that may have utility for researchers, clinicians, and recovery support services.

Keywords: recovery capital; substance use disorder; item response theory; brief scale; alcohol; remission

### 1.1 Introduction

### 1.2

Policy changes have implicated personal health and well-being as important additional primary outcomes to assess in recovery from substance use disorder, also referred to as SUD (Clark, 2007; Davison & White, 2007; Dept. Health and Human Services, 2003; Gagne, White, & Anthony, 2007; Institute of Medicine, 2006; White, 2005), yet clinical research in the US has

focused almost exclusively on abstinence (Donovan et al, 2012). Remission from SUD is increasingly recognized as a dynamic reciprocal process that results in, and is supported by, the accrual of personal, social, environmental, and cultural resources that aid the recovery journey (Kelly & Hoeppner, 2015). Collectively, these resources have been termed, "recovery capital" (Granfield & Cloud, 1999). Recovery capital represents the quantity and quality of internal and external resources that can be brought to bear to initiate and sustain recovery from SUD. The accrual of recovery capital is theoretically important because greater assets will influence resiliency and coping, and can help mitigate the high burden of biological and psychological stress associated with the adaptation to abstinence and remission from SUD (Kelly & Hoeppner, 2015; Laudet & White, 2008). Traditional clinical and research tools often use deficit-based forms of assessment which focus on measuring pathology and harm (e.g., ASI; McLellan et al, 1992). When used alone, traditional tools fail to capture what a review of long-term recovery concluded was one of the strongest predictors of remission: strength-based assessment of resources (White & Cloud, 2008).

The significance of the construct of recovery capital has led to the development and testing of psychometrically and conceptually sound assessment tools. For example, a recovery capital assessment tool (Assessment of Recovery Capital: ARC; Groshkova, Best, & White, 2013) was validated recently showing good psychometric properties and consisted of 50 items representing 10 conceptual subscales. The addition of a briefer version of the ARC, could increase its adoption and implementation in busy clinical and recovery support service settings by increasing speed of administration and scoring; however, this process of scale reduction requires rigorous methodological guidelines to maintain validity.

Item response theory (IRT) and the rasch model of scale development (Rasch, 1960/1980) is a powerful paradigm for scale reduction as it maximizes the efficiency of construct measurement and can help to create briefer measures of equal or greater psychometric value as longer measures of the same domains. IRT methods allow for a precise "diagnosis" of the functioning of each item and response category using a set of interpretative tools (item characteristic, response probability, information curves, differential item functioning, etc.) which provide the bases for item retention in scale reduction (Goetz et al, 2013).

The aim of this study was to work with the original set of 50 items from the ARC (Groshkova et al, 2013) to develop a briefer version that could be deployed more widely in busy clinic/recovery support services settings and in research contexts. The original 50 items are made up of subscales that capture 10 different conceptual domains of recovery capital: substance use and sobriety, global psychological health, global physical health, citizenship and community involvement, social support, meaningful activities, housing and safety, risk-taking, coping and life functioning, and recovery experience. Our goal was to keep as few items as possible while preserving the conceptual model and maximizing its psychometric properties. In doing so we used IRT to identify one item from each of the 10 subscales with the best psychometric characteristics that could be retained and combined to represent a single unified dimension of recovery capital. Similar to current methodological guidelines for shortening composite measurement scales (Goetz et al, 2013), we sought to preserve the content validity and psychometric properties of the original instrument, eliminate differential item functioning (DIF) and item redundancy, document the empirical and conceptual reasons for the item selection, and validate the short instrument (Brief Assessment of Recovery Capital, BARC-10) in an independent sample.

## 2.1 Method

## 2.2 Participants

Secondary data analyses were performed on the original treatment sample from Scotland used to field-test the Assessment of Recovery Capital (ARC) in 2010 (Groshkova et al, 2013),

and a treatment sample from Australia collected in 2015 (Best et al, 2016). The treatment sample from Scotland (*n* =142) was recruited from four community rehabilitation services. Of the 142 individuals, 62.7% were men, 69% were white British and 31% were of other ethnicity. The average age at time of assessment was 35 (± 12.3). Alcohol was the primary substance reported by 35.3% of the sample, other drugs were reported by 31.6 %, and 33.1% indicated both alcohol and other drugs. A detailed description of the study design and characteristics of the sample from Scotland are published by Groshkova and colleagues (2013).

The other treatment sample (*n* =308) was recruited from five Therapeutic Communities on the east coast of Australia. Of the 308 individuals, 67.9 % were male, 89.6% were born in Australia and the rest were from the United Kingdom (2.6%) or New Zealand (1.6%). The average age was 35 years (± 9.2). The majority reported a drug (other than alcohol) to be their primary substance (63.6%) while 33.1% reported alcohol as primary. A detailed description of the study design and characteristics of the sample from Australia are published by Best and colleagues (2016).

Our goal was to develop a brief measure of recovery capital by retaining the treatment samples from Scotland and Australia for three reasons: 1- we seek to be as consistent with the original ARC development as possible thereby incorporating the original sample, 2- a brief measure of recovery capital that is validated on diverse samples will have wider utility, and 3- suggestions for future DIF guidelines (Zwick, 2012) stated that in order to increase sample size, if necessary, pooling data from beyond a 12 month interval should be considered to increase stability of results.

### 2.3 Measure

The ARC (Groshkova et al, 2013) is a self-report, strength-based measure of an individual's personal and social resources that can support recovery from a SUD and contains 50 items. Participants are asked to respond by placing a check mark in the box for the statements that they agree with and that describe their experience on the day of assessment. The participant's response is then recorded and entered as a binary response option (agree/disagree). The 50 – items are divided into 10 subscales (5 items per subscale) to assess the following conceptual domains: substance use and sobriety, global psychological health, global physical health, citizenship and community involvement, social support, meaningful activities, housing and safety, risk-taking, coping and life functioning, and recovery experience. Subscale scores are calculated by summing the items. Thus, a score between 0 and 5 can be reached for each subscale. The ARC also can be scored by separating the 50-items into subscales of personal versus social recovery capital and summing the scores on 25 items in each domain. An overall total score is the sum of each subscale score and can range from 0 to 50. Higher scores indicate greater levels of recovery capital.

### 2.4 Analysis Plan

**2.5 Unidimensionality.** Evidence of unidimensionality, or finding a single underlying pattern in the data matrix, is an assumption of using the Rasch model. The original ARC was designed to have a strong unidimensional component as described in Groshkova et al. (2013). They reported a single factor was extracted from ten subscales using a principle components analysis (PCA) which was confirmed by a Bartlett's test of sphericity and Kaiser-Mayer-Olkin measure of sampling adequacy. This means that although the ARC has ten subscales, they are more conceptual than empirical (i.e., PCA does not produce 10 different factors) and may be represented by a common construct. The samples from Scotland and Australia could be heterogenous so we will use PCAs to inspect for differences in the subscale factor structure and assess the degree of empirical support for pooling the samples. If we find the factor structures are similar in the number of factors produced and range of the loadings, we will use PCA to assess the subscale factor structure of the pooled samples. The criterion suggests that the first

component should be ≥ 20% (Reckase, 1979), the ratio of the first to second eigenvalue should be at least 3 to 1 in order for the scale to be considered unidimensional (Lord, 1980).

**2.6 Best fitting model (1-PL vs. 2-PL).** We compared the fit of the one-parameter logistic model (i.e., 1-PL also referred to as the Rasch Model) to the two-parameter logistic model (2-PL) using the program BILOG-MG (Zimowski, Muraki, Mislevy, & Bock, 1996). The "one parameter" makes reference to the only defining characteristic of the Rasch model: item difficulty ($\beta$). The 2-PL is an extension of the 1-PL through the addition of an item slope or discrimination parameter ($\alpha$). An items discrimination indicates how strongly the item is related to the latent trait, similar to a factor loading in classical test theory. Items with high discrimination are better at differentiating respondents around the location point ($b$) (i.e., the amount of the latent trait needed to have a 50% chance of endorsing the item), thus increasing measurement precision. The 1-PL (Rasch, 1960/1980) and the 2-PL (Birnbaum, 1968) are appropriate for analyzing ordered dichotomous response formats where respondents rate their level of agreement with a statement using two categories (e.g., agree/disagree). We used the best fitting model to test for DIF and then select items for retention in the scale reduction process.

**2.7 Differential item functioning (DIF).** A test item is labeled with DIF when examinees with equal ability (i.e., matched or "controlled for" on the underlying latent trait referred to as theta [θ]), but from different groups, have an unequal probability of endorsing the item. In other words, if the response to an item is dependent on group membership, the test item is not invariant across groups (also referred to as item bias). A test of DIF would provide further empirical information if the samples from Scotland and Australia were similar enough to be pooled into a single calibration sample by inspecting for invariance in the difficulty ($b$) and discrimination ($\alpha$) parameters. After eliminating items that are labeled with DIF between locality we pooled the reports into a single calibration sample and tested for DIF between sex.

Since our goal was to eliminate as many items as possible while still retaining conceptual representation from each of the ten subscales, we adopted flagging rules based on statistical significance ($p < .05$) with Mantel-Haenszel as opposed to rules associated with clinical or practical significance which can produce more conservative results when the goal may be to retain scale items based upon the impact of DIF (Scott et al, 2010).

**2.8 Comparison of psychometric properties.** We tested whether the BARC-10 had equivalent psychometric properties to the original ARC by comparing the internal consistency and concurrent validity between the two measures.

**2.9 Independent sample validation.** We piloted the BARC-10 in a battery of measures as part of a survey of members from InTheRooms.com, an online community of individuals in or seeking recovery, primarily for SUD. InTheRooms.com hosts more than 400,000 individuals, and is designed to facilitate peer interaction and recovery support through many online resources including, but not limited to "chats" and live online video meetings. A detailed description of the study design and sample characteristics can be found elsewhere (Bergman, Kelly, Hoeppner, Vilsaint, & Kelly, in press).

**2.9.1** ***Category response functioning.*** The original 50 – item ARC had participants respond by marking a tick next to the boxes for the statements that they agree which is then recorded and entered as a binary response option (agree/disagree). We expanded the response options to six categories for two reasons. First, instruments with binary response categories can fail to capture the nuances of the construct which may be more apparent in a brief 10-item measure compared to a more comprehensive 50-item measure. Second, multiple response options increase sensitivity and thus the ability to make finer discriminations. This is especially important when measurements are used to make decisions about an individual rather than a group trait (Frank-Stromborg, 2004) which is a common condition in clinical research. Therefore, we piloted the BARC-10 in an independent sample with the following six-point Likert scale response categories: *(1) strongly disagree, (2) disagree, (3) somewhat disagree, (4) somewhat*

*agree, (5) agree, and (6) strongly agree*. Scores can range from a minimum of 10 to a maximum of 60.

We used the Partial Credit Model (PCM; Masters, 1982) to examine response categories functioning in the program WINSTEPS (Linacre, 2011). PCM is appropriate for testing if polytomous response formats, where respondents rate their level of agreement with a statement on a multi-point scale, are indeed ordered. The PCM makes no constraints about step difficulties (intersections between response categories), so step difficulties can differ across different items and will reflect if the Likert scale functions in a meaningful way. Unlike the Graded Response Model (Samejima, 1969), the PCM provides an empirical test of the assumption that categories are ordered which can be useful for item screening during in an initial validation such as this.

Average measures, step calibrations, and fit statistics were examined to test whether the response categories behaved sufficiently well. Average measures (i.e., ability / trait level estimates of theta $\theta$, which is recovery capital in this case) and step calibrations are expected to increase with increasing response categories. Violation of this pattern indicates the response categories are disordered, or reversed. In addition, we used category fit indices (infit and outfit) and category probability curves to provide additional information about functioning of response categories. Infit and outfit statistics reflect the degree of unexpectedness in the data. Infit is sensitive to patterns of misfit in the data responses than would otherwise be predicted by the model. Outfit is sensitive to unusual responses such a highly able person failing to endorse an easy item. The categories are considered as misfitting if infit or outfit statistics were less than .5 or greater than 2 (Linacre, 2011).

**2.9.2** ***Predictive validity.*** To determine and compare the sensitivity (SN) and specificity (SP) of the BARC – 10 as an indicator of sustained remission ($\geq$ 12 months of abstinence) and obtain its optimal cut-off scores, a receiver operating characteristic (ROC) curve was examined. Validity coefficients (SN, SP), and the area under the curve (AUC) and its associated 95% confidence interval (CI) were calculated. Optimal cut-off scores were determined by assessing the score, which combined maximum SN and optimal SP, using the Youden index (Perkins & Schisterman, 2006; Fluss, Faraggi, and Reiser, 2005).

**2.10.1** ***Test information function (TIF).*** TIF is similar to classical test theory in the concepts of reliability and standard error. We examined the TIF to determine which raw scores on the BARC-10 have the highest measurement precision.

## 3.0 Results

### 3.1 Unidimensionality

Evidence provided by Groshkova and colleagues (2013) showed the underlying factor structure of the ARCs ten subscales can be represented as a single linear component. Consistent with the original design we ran a PCA to test the unidimensionality of the ARC using SPSS v.22. Both the samples from Scotland and Australia yielded a single linear component that accounted for 59.1% and 54.2% of the variance respectively in the 10 subscale scores. In addition, the Scotland sample had loadings between .54 and .83 which was similar to the Australian sample loadings that ranged between .60 and .78. The PCA's suggested that a highly similar dominant dimension existed in the underlying subscale structure of the data so we combined the samples and ran a final PCA. Using pooled samples, a PCA yielded a single factor that accounted for 55.1% of the variance, which was larger than the recommended criterion of 20% (Reckase, 1979). Loadings from the pooled samples ranged from .62-.79. suggesting that there was a dominant dimension present in the underlying data structure.

### 3.2 Best Fitting Model (1PL vs. 2PL)

We compared the model fit by calculating the –2 log likelihood difference between the 1PL and 2PL. The resulting chi-square difference was 212.04, with 10 *df* ($p < .001$), which indicated the more complex model (2PL) was the best fit to test for DIF and complete the scale analysis for item retention.

### 3.3 Differential Item Functioning

Despite the smaller sample sizes, we found significant DIF for one item when comparing the treatment samples from Australia ($n_R$ = 308) to Scotland ($n_F$ = 142). We then pooled the treatment samples and found no DIF between men ($n_R$ = 297) and women ($n_F$ = 148). The DIF analysis provided additional support that the samples were similar enough to be pooled into a single calibration sample. We eliminated the item labeled DIF before completing the scale analysis and item selection.

### 3.4 Item Selection

Our goal was to keep as few items as possible while preserving the conceptual model and maximizing its psychometric properties. Therefore, we retained a single item from each narrowband subscale to keep the conceptual pieces of recovery capital intact. We used a strategy that would maximize psychometric properties and efficiency by selecting items with high discrimination, spanned a wide range of item difficulty, and eliminated items that measured the same level of difficulty twice (i.e., redundancy). The final items and corresponding parameter estimates retained for the BARC-10 are displayed in Table 1.

### 3.5 Comparison of Psychometric Properties

The BARC-10 retained similar psychometric properties of the original ARC which has an internal consistency of α = .92 compared to the BARC-10 α = .90. The concurrent validity between the ARC and BARC-10 is high at $r_{pb}$ =.90.

Table 1

*BARC -10 Scale Items with Corresponding Item Parameter Estimates for Threshold (i.e., difficulty) and Slope (i.e., discrimination) with Standard Error (S.E)*

| | IRT Parameter Estimates | |
|---|---|---|
| Item | Threshold<br>S.E. | Slope<br>S.E. |
| There are more important things to me in life than using substances | -2.01<br>0.21 | 1.47<br>0.23 |
| In general I am happy with my life | 0.18<br>0.06 | 1.98<br>0.22 |
| I have enough energy to complete the tasks I set for myself | -0.49<br>0.08 | 1.82<br>0.23 |
| I am proud of the community I live in and feel a part of it | -0.48<br>0.09 | 1.35<br>0.17 |
| I get lots of support from friends | -0.63<br>0.10 | 1.36<br>0.18 |
| I regard my life as challenging and fulfilling without the need for using drugs or alcohol | -0.30<br>0.06 | 2.00<br>0.23 |
| My living space has helped to drive my recovery journey | -0.65<br>0.09 | 1.44<br>0.18 |
| I take full responsibility for my actions | -1.64<br>0.17 | 1.31<br>0.17 |
| I am happy dealing with a range of professional people | 1.53<br>0.18 | 1.31<br>0.19 |
| I am making good progress on my recovery journey | -1.32<br>0.11 | 1.95<br>0.24 |

## 3.6 Independent Sample Validation

**3.6.1 Participants.** Of the *N* = 123 respondents from InTheRooms.com, the average age was approximately 51 years, 43% were male, 94% white, and approximately 45% were employed full-time. Two-thirds (≈ 64%) identified alcohol as their primary substance and the mean length of time abstinent was 7.34 years (± 9.25). The sample had extensive treatment histories, with 65% reporting participation in outpatient addiction treatment, almost 50% had

used medical detoxification, and 60% inpatient/residential. The mean total score on the BARC-10 was 50.70 (± 6.91).

**3.6.2 Category response functioning.** Overall, the PCM supported the use of a six – point Likert scale response category. Within each item, the average measures and step calibrations increased monotonically as the rating scale moved from lower to higher categories. The category response curves also showed successive response categories each located in the expected order. This meant that each category was the most likely to be endorsed according to a corresponding trait level and there is no reason to consider collapsing response categories. Inspection of the category fit indices showed that each of the six response categories showed acceptable infit mean-square statistics (between .96 - 1.79) and all categories had acceptable outfit mean-square statistics with the exception of one (between .94 - 2.45), *strongly disagree* which was 2.45.

**3.6.3 Predictive validity.** Sensitivity (SN) and specificity (SP) values for different cut-off points were computed and a ROC curve was constructed to determine the best cut-off to choose. The estimated ROC curve had an AUC of .79 (95% CI .71 - .86) which indicates the BARC-10's concurrent validity with sustained remission ($\geq$ 12 months of abstinence). The hypothesis was tested whether the AUC was greater than .5, that is whether using the BARC – 10 to predict recovery stage is better than chance alone. The AUC = .79 (95% CI .71 - .86) ($P < .0001$), suggesting the BARC-10 does help to predict recovery stage. Next, Youden indices were calculated for a range of possible cut-off points using SN and SP values for the BARC-10 total score. According to the ROC curve above and guided by the *J*-values, the optimal cut-off level yielding maximal SN and SP for predicting early recovery or later (i.e., 1 year or more) was a BARC-10 score of 47 (SN = 84%; SP = 65%, at J = .53).

**3.6.4 Test information function (TIF).** TIF is an indicator of measurement precision and can be determined at any level of ability, or in this case, any level of recovery capital. For ability estimates of theta ($\theta$) that range between −2.40 and 2.03 the scale measures with greater than 80% reliability. This means the BARC-10 is over 80% reliable on raw scores between 15 to 53.

## 4.0 Discussion

This is the first empirical study to develop a brief version of the original 50-item ARC (Groshkova et al, 2013) using item response theory. We shortened the ARC by eliminating items that showed DIF and item redundancy, retained one item from each of the 10 narrowband subscales that had the best psychometric properties to maintain content validity and represent a single unified dimension, and validated the brief instrument in an independent sample. After piloting the BARC-10, we used the PCM to determine that a six-point Likert scale was empirically supported and each response category had meaning relative to a corresponding trait level. We used a ROC curve analysis to test the ability of the BARC-10 to identify individuals who had reached self-reported sustained remission and found that 12 months or more of abstinence from alcohol and other drugs was associated with a score of 47. The resulting BARC-10 is a 10 – item measure which is invariant across groups based on locality and sex. The BARC-10 can be completed in approximately one minute, has high content validity capturing the same 10 domains of recovery capital used to develop the original instrument, and possesses equivalent psychometric properties.

The need for measures of recovery capital is driven by a paradigmatic shift in the field of addiction recovery and reinforced by policy changes (Clark, 2007; Davison et al, 2007; Dept. Health and Human Services, 2003; Gagne et al, 2007; Institute of Medicine, 2006; White, 2005). Similar to the ARC, the BARC-10 measures the quantity of broader personal, social, physical, and professional resources in an individual's environment that are used to initiate and sustain recovery as well as structural supports such as a recovery-supportive living space and community relationships, but in a briefer version with equally good psychometric properties and

a high correlation with the longer measure. As such, it offers an alternative measure of recovery capital in settings where brevity is valued.

The BARC-10 provides an index of recovery progress that extends beyond mere abstinence. As such, it might be used as measure of the positive outcome benefits accrued as individuals abstain or reduce their substance use. Additionally, it may serve as a useful proximal/intermediate measure to assess mechanisms of behavior change as greater accrual or recovery capital may predict future abstinence and remission (Kelly et al, 2015). Evaluation and progress measures can provide valuable insight to both program evaluation and patients' success, and is often of interest (or requirement) of insurance companies. As important payers and other stakeholders in the field continue to scrutinize the recovery construct (Knopf, 2001; El-Guebaly, 2012) it is important to have measureable indicators of recovery progress beyond self-reported abstinence, objective urine, and blood tests.

### 4.1 Limitations

Findings from the current study should be viewed in light of important limitations. One such limitation is the lack of verification of self-reported recovery time. In addition, the mean score on the BARC-10 was almost 50 which may suggest a ceiling effect given the maximum score is 60; however, this should be considered in light of the mean length of recovery time in the sample which was approximately 7.5 years (i.e., maintenance or long-term recovery). A strength of the measure is its cross-validation in international treatment samples; however, the we used convenience samples that could have some heterogeneity and the psychometric properties should be further evaluated in other samples. Furthermore, the extent to which clinicians find the BARC-10 helpful in establishing care plans and ranking priorities in ongoing client support is yet to be investigated. As noted by Groshkova and colleagues (2013), an important line of future research is to determine the degree to which various profiles of recovery capital combined with symptoms of problem severity predict levels of care and post-intervention recovery outcomes.

### 4.2 Conclusion

With the aid of Item Response modeling and its wide acceptance as a gold standard for refining and reducing the length of existing scales in the social, medical, and educational sciences we have been able to reduce scale length without undermining its psychometric properties. As such, the briefer BARC-10 may serve as a potentially helpful additional tool for researchers, clinicians, health care systems and electronic health records, as well as peer-to-peer recovery support services where brevity is needed.

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# Selected Papers of William L. White

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## Prevalence, Pathways, and Predictors of Recovery from Drug and Alcohol Problems in the United States Population: Implications for Practice, Research, and Policy

### Abstract

**Background**: Alcohol and other drug (AOD) problems confer a global, prodigious burden of disease, disability, and premature mortality. Even so, little is known regarding how, and by what means, individuals successfully resolve AOD problems. Greater knowledge would inform policy and guide service provision.

**Method**: Probability-based survey of US adult population estimating: 1) AOD problem resolution prevalence; 2) lifetime use of "assisted" (i.e., treatment/medication, recovery services/mutual help) vs. "unassisted" resolution pathways; 3) correlates of assisted pathway use. Participants (response = 63.4% of 39,809) responding "yes" to, "Did you use to have a problem with alcohol or drugs but no longer do?" assessed on substance use, clinical histories, problem resolution.

**Results**: Weighted prevalence of problem resolution was 9.1%, with 46% self-identifying as "in recovery"; 53.9% reported "assisted" pathway use. Most utilized support was mutual-help (45.1%,SE = 1.6), followed by treatment (27.6%,SE = 1.4), and emerging recovery support services (21.8%,SE = 1.4), including recovery community centers (6.2%,SE = 0.9). Strongest correlates of "assisted" pathway use were lifetime AOD diagnosis (AOR = 10.8[7.42–15.74], model R2 = 0.13), drug court involvement (AOR = 8.1[5.2-12.6], model R2 = 0.10), and, inversely, absence of lifetime psychiatric diagnosis (AOR = 0.3[0.2–0.3], model R2 = 0.10). Compared to those with primary alcohol problems, those with primary cannabis problems were less likely (AOR = 0.7[0.5–0.9]) and those with opioid problems were more likely (AOR = 2.2[1.4-3.4]) to use assisted pathways. Indices related to severity were related to assisted pathways (R2 < 0.03).

**Conclusions**: Tens of millions of Americans have successfully resolved an AOD problem using a variety of traditional and non-traditional means. Findings suggest a need for a broadening of the menu of self-change and community-based options that can facilitate and support long-term AOD problem resolution.



# Strengths Planning
## for Building Recovery Capital

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For decades, addiction professionals have been providing screening and assessment instruments that evaluate problem severity, complexity, and chronicity, but offer little data on internal and external resources individuals and families can mobilize in resolving such problems (White & Cloud, 2008). This status is changing with a new generation of instruments that have profound implications for the future of addiction treatment and addiction counselling.

This development is consistent with a recovery movement (e.g., White, 2006; White, 2007) that is predicated on the transition from a pathology to a strengths-based model in which the pathway to sustained recovery is seen as the accrual of resources and capabilities more than the successful management of illness (White & Cloud, 2008). This model is gathering ground across domains of social care and health and includes not only addiction and mental health recovery, but positive psychology and criminology (Ronel & Segev, 2015), and a diverse range of criminal justice approaches including restorative justice (Zehr, 2002) and therapeutic jurisprudence (Wexler, 2000). These approaches are all advocating a holistic model that engages not only the protagonists but also families and communities; emphasizes relationships and community integration; and focuses on well-being and quality of life (De Maeyer, Vanderplasschen, & Broekaert, 2009).

Building on the language of social capital (Putnam, 2001), recovery capital has been defined as "the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation" (Cloud & Granfield, 2008, p. 1972). Granfield and Cloud (2001) had previously coined the term "recovery capital" and described what they regarded as its four primary domains: social capital, physical capital, human capital, and cultural capital. Best and Laudet (2010) subsequently developed a tripartite model based on personal, social, and community recovery capital.

Although the term has been used extensively, it has remained poorly operationalized and only recently have there been systematic attempts at creating scales and measures for recovery capital. The most widely cited of these is the Assessment of Recovery Capital (ARC; Groshkova, Best, & White, 2013), a fifty-item scale that has two domains—personal recovery capital and social recovery capital—both consisting of five subscales of five items each. However, this measure has primarily been used in research studies and its application in clinical practice has been limited, meaning that recovery capital is a term that is widely deployed but poorly articulated in many addiction recovery settings.

This gap has been addressed through developing an extended version of the ARC that examines not only recovery capital but wider measures of well-being, motivation, involvement in recovery groups and social support, and barriers to recovery in the form of unmet support needs and acute substance-related and lifestyle factors. This measure, called the "REC-CAP," takes around fifteen minutes to complete and is described in a recent paper by Best and colleagues (2016a). However, what is unique about the REC-CAP is that it is a measure of recovery barriers and strengths, and provides a method for translating this evidence-based summary of needs and strengths into a recovery care planning approach. The data are drawn from a partnership between the Helena Kennedy Centre at Sheffield Hallam University and the Florida Association of Recovery Residences (FARR).

## Rationale and Method

The REC-CAP is both an innovative assessment tool and a method of creating and operationalizing an evidence-based recovery care planning and review process with direct links to community engagement.

The assessment measure is designed for use across a range of contexts including specialist addiction treatment services, peer-based recovery support services (White, 2009), and as a self-completion and self-help tool for individuals in the later stages of their recovery journeys. Essentially there are four blocks to the REC-CAP:

### Block One

Following basic demographic information, the first block assesses acute problems individuals have in five domains—substance use, risk taking, housing, criminal justice, and lack of meaningful activities—and assesses unmet specialist support and treatment needs across these and other areas.

### Block Two

The second block assesses recovery capital, resources in the domains of personal and social capital, recovery group participation, social support, well-being, quality of life, and commitment to sobriety.

### Block Three

One of the concerns of any standard instrument is that it does not allow sufficient scope for personal experiences and subjective needs. Therefore, following the structured parts of the REC-CAP, the third block is an open-ended section where individuals are encouraged to report their experiences and needs.

### Block Four

The fourth block is predicated on successful coding and scoring of the first two sections and is the translation of the summary of scores into a node-link map that initiates the process of recovery care planning. The data from the assessment provide a systematic way of populating the initial "Your Recovery Well-Being" map and are then broken down through two further mapping exercises—"Continuing the Journey of Recovery" and "Recovery Planning: Setting a Goal"—to help people in recovery translate their needs and strengths into an action plan based on their own subjective experiences and perceptions, and based on the evidence from the REC-CAP (as shown in the two case studies we will provide).

The online version of the assessment and care plan also provides the opportunity for direct linkage into the third part of the REC-CAP model (i.e., a method of linking into community resources and assets). Based on a strong and clear evidence base that recovery progress is significantly enhanced by spending more time with others in recovery (Longabaugh, Wirtz, Zywiak, & O'Malley, 2010) and by engaging in positive and meaningful activities (Best, Irving, Collinson, Andersson, & Edwards, 2016b), the third stage of the model offers linkage opportunities for people who do not have access to this form of recovery capital, which is most people leaving acute drug and alcohol treatment.

Based on a three-month assessment and review cycle, the REC-CAP system employs an "MPE" process to do three things:

1. **Measure:** Identify barriers to recovery and resources people have to overcome these
2. **Plan:** Use these data to create the basis for a recovery care plan that sets goals and outlines a strengths-based way to achieve these goals
3. **Engage:** Provide links to activities and groups in the local community that can help individuals achieve the goals they have set

## Preliminary Findings

The findings outlined next are for one hundred of the first cases that have been collected as part of the pilot program with the Florida Association of Recovery Residences (FARR). Following this analysis and presentation of strengths and needs, two cases are analysed in more depth. Eight recovery residences in Florida participated in the project, engaged a total of 630 clients at various stages of their stay in the residences, and completed the REC-CAP assessment.

The method relies on a visualization approach that uses traffic lights for rapid recognition of areas that are strengths (in green), areas that are neither weaknesses nor strengths (in amber), and areas that require further attention (in red). The purpose of this traffic lighting system is to allow both workers and recovery residents to have an "instant and holistic" picture of where they are in their recovery journeys so they can move immediately into planning and action phases.

The presentation method provides a snapshot of overall functioning that can be used either at an individual level (as in the case studies presented later in this article) or as an aggregate across a population as shown in Figure 1 (below), where key findings are outlined for each of the domains of the REC-CAP.

In summary, the top box ("Quality of Life & Satisfaction") shows generally high levels of reported well-being, particularly around satisfaction with accommodation and social support.

In the second and third boxes ("Barriers to Recovery" and "Service Involvement & Needs"), barriers and ongoing support needs with the current sample are reported, showing some problems with ongoing substance use—including both illegal and legal substances (e.g., tobacco, alcohol, and prescribed medication)—and lack of meaningful activities as more prevalent barriers, with additional support needs most commonly identified in the areas of primary health care and family support. In sum, half of the cohort report at least one barrier, with a mean and median of two barriers each for those fifty residents.

Finally, the bottom box ("Recovery Strengths") indicates that there is strong recovery capital across the board, but particularly in the areas of recovery experience (e.g., perceived strength and confidence in recovery) and in citizenship—which is largely around community involvement and engagement—with high levels of participation in community recovery groups and activities, and in the local community. Finally, the sample typically reported very high levels of abstinence self-efficacy. Thus, this is a population who generally have the personal, social, and community recovery capital to sustain the belief that they can be the drivers of their own recovery journeys.

The primary purpose of the REC-CAP is around individual cases, but the point

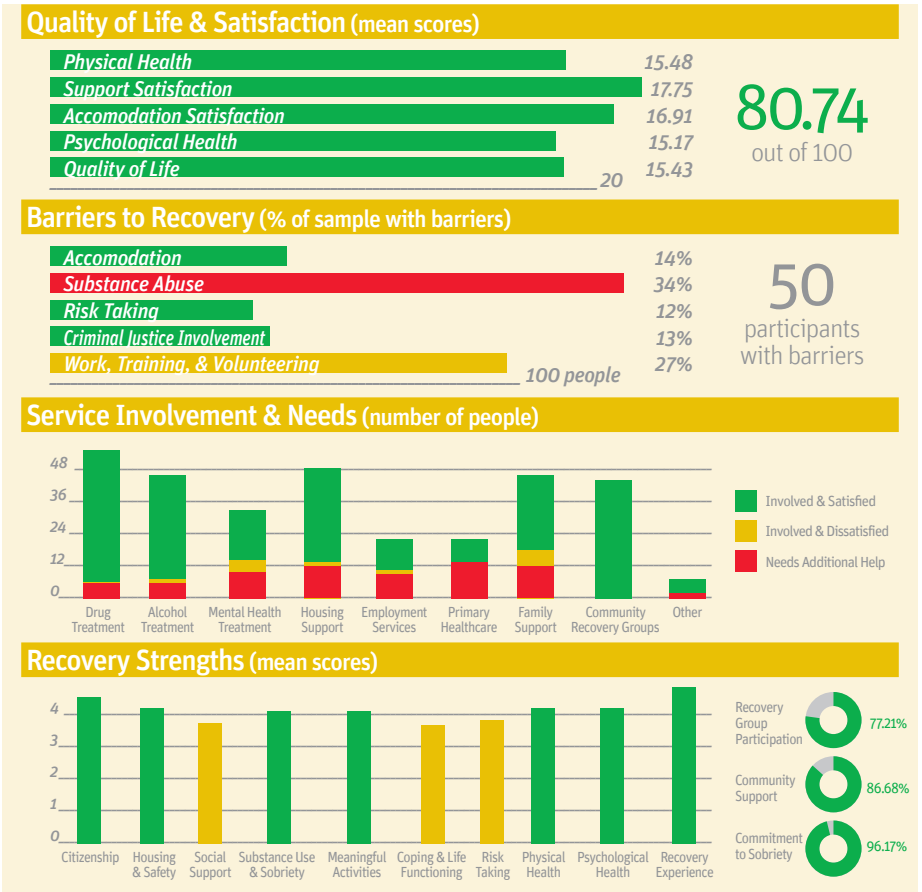


*Figure 1. Overview of Recovery Capital, Barriers, and Needs for the First 100 Cases*

of showing the summary dashboard in Figure 1 is to show the capability of the model as an outcome monitoring or performance management system at team or even locality levels. This can be done both for current functioning as in Figure 1 or as a measure of change over time, demonstrating where treatment centers are achieving successes and where there are blocks that need to be overcome.

## Case Studies

Two case studies were selected to illustrate different phases of recovery progression and their implications for the care planning process. The first case is from a resident in early recovery.

### Case Study #1: Angela

Angela has just come out of detoxification for methamphetamine dependence, although she also has a long-standing alcohol problem. She has suffered both physically and mentally as a result of her addictions and this is evident from the score profile she shows at the initial REC-CAP completion close to the start of her stay in a recovery residence. The summary page is shown in Figure 2 (below).

In Angela's case, there are several immediate barriers to the growth of recovery capital. She has both recent substance use (a meth binge prior to undertaking detox) and no involvement in any education, training, or volunteering in large part because of her physical and mental health. Furthermore, in terms of support needs, while currently receiving support in the areas of mental health, substance use, and family support, none of these is sufficient to meet her perceived needs, and it is not clear yet whether these are directly linked to her recent binge or not. Therefore there are key issues to address in acute functioning and treatment for Angela and the need for additional support in mental health, substance use, and family involvement. All of these things have to be initiated before it makes sense to focus on building recovery capital. However, that does not mean Angela does not have strengths that can be used to support her in her journey.

As a result, while it is not surprising to see low levels of recovery capital, particularly in the domain of personal recovery capital, there are areas to work on. Each subscale is scored between zero to five, with higher scores representing better functioning and red-colored scores (zero or one) indicating little resource in this area. For this individual, there is only one area (around housing and security) that is a genuine recovery resource, but this feeling of safety about living in the recovery residence provides a strength on which to build. For the other domains measured, only motivation—measured on the "Commitment to Sobriety" scale—would suggest a real recovery asset. However, on overall well-being, Angela has scored high on feelings of physical well-being (in spite of ongoing health symptoms, and probably indicative of recent improvements), accommodation, and support, so these are also included in the asset list. The evidence from the scale would suggest that there are acute treatment and lifestyle issues that need to be addressed and only Angela's motivation, health, support, and secure accommodation represent real recovery strengths. This is then translated into the recovery well-being map.

The recovery well-being map is a visualization map (Dansereau, 2005), and to make its impact greater and for continuity with the rationale for the presentation of data findings, areas that are strengths are depicted in green, neutral areas of functioning in amber, and areas to be addressed in red. Angela's own subjective experiences and goals—personal recovery beliefs are central to any recovery model—are inserted into the central bottom box to ensure that there is a marriage between the scoring of the scale and what residents perceive their needs to be. As would frequently be the case with people early in recovery, the aspirations are ambitious and long term. Peer recovery navigators and residents will then use this overview to assess how it fits with clients' subjective experiences, review what has gone on, and plan the next stages of recovery activity moving forward. The subsequent maps will attempt to break down these long-term goals and to use the strengths identified to help individuals take steps towards achieving them. The aim for Angela is to keep her sober, get her fit and healthy, and build on her growing social supports to create the space

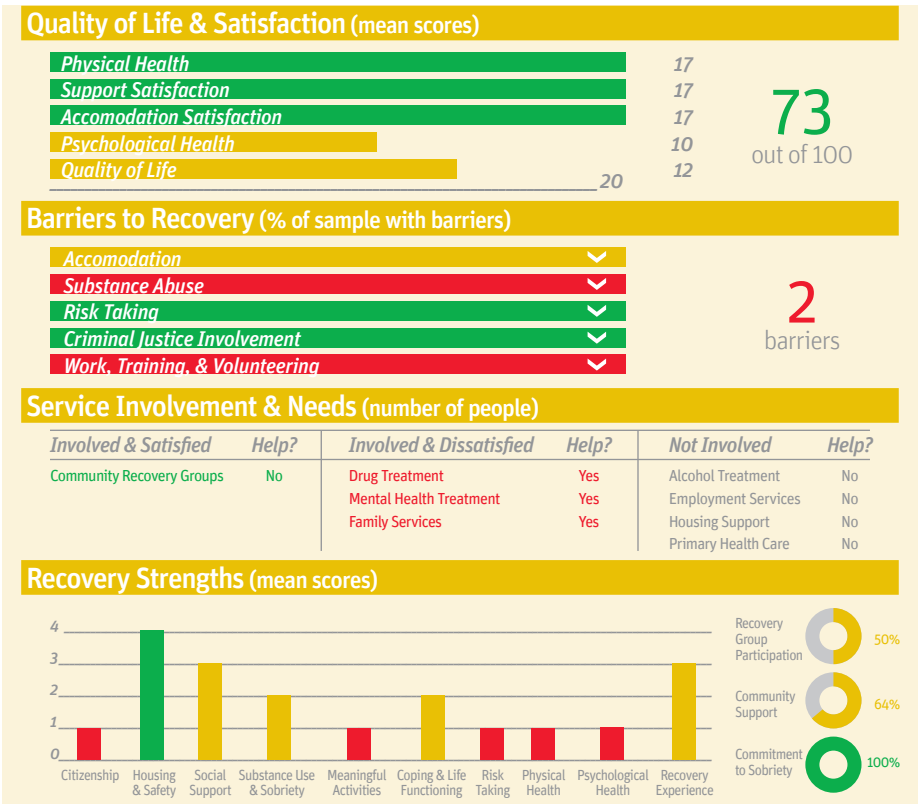


*Figure 2. Angela: An Early Recovery Resident Case Summary*

to build the personal and social capital that will allow her to engage in the community and have the self-determination and assets to achieve her goals.

## Case Study #2: JoAnne

The second case study is for a resident who is much more established in recovery. JoAnne had a long-standing battle with alcoholism that has seen her enter treatment and recovery services on a number of occasions over the course of twenty years. However, she has completed treatment, has become established in the recovery residence, and has made progress on various fronts. In her case there are no acute risks or unmet service needs, evidenced by the lack of red flags in the barriers to recovery section. All of the well-being indicators are positive and, very unusually, JoAnne scores a maximum on the ARC. She is also committed to sobriety, has good community support, and is well engaged in recovery groups in the community (see Figure 3 below).

What this means, translating those assets to the recovery well-being map, is that there is a very positive story for JoAnne and her peer recovery navigator to tell around progress and achievement with only some concerns about accommodation emerging from the summary data. And a core part of the navigator's role is celebrating success and building strengths and capital from success. The strong recovery resources reported reflect considerable recovery assets to deploy in meeting the two subjectively set goals around parenting and completing nursing school, although the recovery coach or worker may well want to discuss mental health support needs as well. Thus, the task in the subsequent maps is to break down those objectives into more manageable units and tasks and to deploy those support systems and personal resources to achieve these goals. JoAnne has done well and the recovery capital she has developed is key both to preventing relapse and to achieving these big, longer-term life goals.

## Overview and Future Directions

The data presented in this article is part of the development of a new method for measuring and mapping recovery capital that builds on established research scales, but does so in a way that is accessible and applicable to both recovery care planning and self-monitoring. The REC-CAP yields a single page summary of scores that address barriers and needs, but also (and critically) identifies strengths across a range of domains of personal, social, and community recovery capital (Best & Laudet, 2010). The data can be presented as a single-page summary at both case and aggregate levels and crucially this can be translated into visualization maps that can initiate a structured process of recovery planning, as is shown in the two case studies. What is new about the REC-CAP is that it is a strengths-based assessment and review measure that directly informs recovery care planning and affords access to community resources to help individuals achieve their goals through the MPE process. It is an ongoing model of strengths building that is predicated on tapping into social supports and community resources as a way of achieving goals and building personal recovery strengths.

Across the entire sample of one hundred cases presented in this study, there is strong recovery capital and well-being, although there is considerable variation in well-being within the sample. As Figure 1 illustrated, there are residual barriers to recovery in parts of the population and additional treatment and support needs. The assumption made in this model is that recovery is a process of building strengths over time. But the recovery journey is not linear and the gradual accrual of recovery resources requires the monitoring and management of setbacks related not only to substance use, but other key life domains as well.

Additionally, the model assumes, as evidenced in the data, that while there are likely to be a series of ongoing support needs from professional services for some people in their recovery journey, it is necessary to monitor whether the support received is sufficient in addressing barriers to stable recovery. While both barriers and additional needs applied to relatively small subsamples, they are crucial to flag in developing recovery reviews and planning models.

At the core of this approach is the assumption that it is the recovery capital

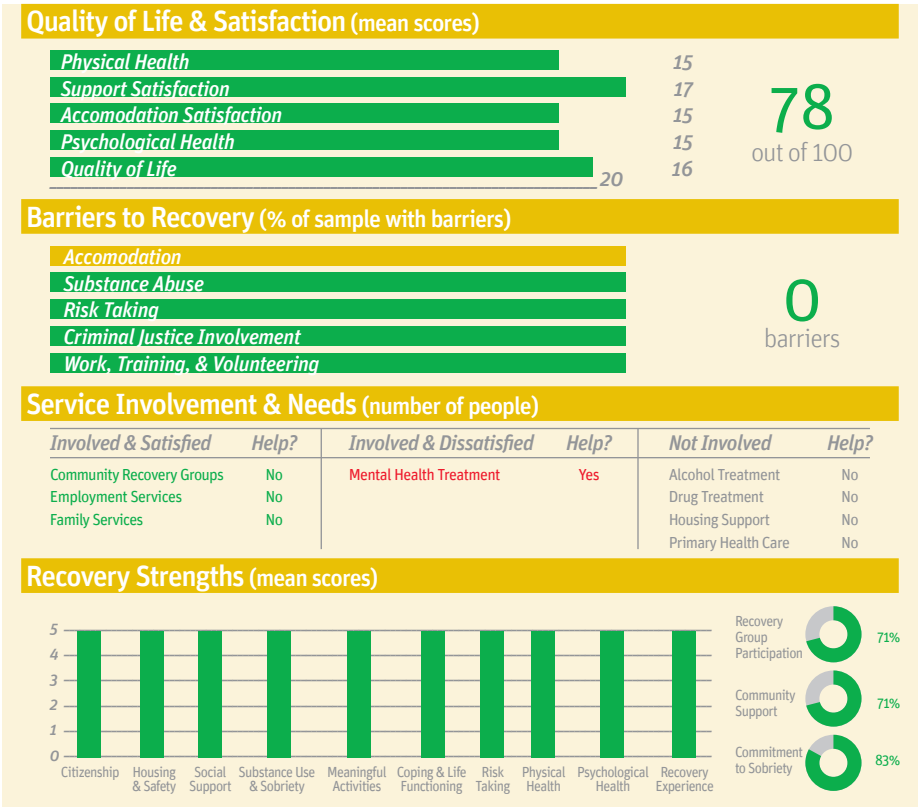


*Figure 3. JoAnne: An Established Recovery Resident Case Summary*

individuals have access to that is the starting point in addressing barriers and in building ongoing recovery capital—this means not only personal skills and strengths but social supports and community resources that individuals are linked into. Those resources may include professionals, but the initial resources are more likely to be embedded in peers, families, and communities, and the REC-CAP is designed to plan for recovery based on active engagement in activities and positive networks. The model and approach were well received by both clients and staff in the participating recovery residences and had face validity in terms of both completion of the measures and the underlying model behind the tool based on a single day of training.

It is important to point out that this is a work in progress in three different areas:

1. We are currently working on an electronic version of the REC-CAP (i.e., the e-REC-CAP) that will automatically populate the initial screen of the recovery plan, which will have significant implications for the speed of feedback and its utilization in the therapeutic, review, and planning process.

2. The e-REC-CAP will be piloted in the next phase of the partnership with the recovery residences in Florida, allowing us also to test the extent to which the care plans are acceptable and engaging for both treatment staff and clients.

3. We are going to have a repeated assessment with a sample of FARR services so that instead of the "static" presentation reported here, we can map change and growth in recovery capital over time and the associated visualizations associated with that change.

This work is developing an application of the principles of recovery systems and recovery capital as a mechanism for supporting and empowering recovery growth by utilizing simple, accessible, and strengths-based measurement tools that use evidence-based models. This work will contribute to the ongoing emergence of a strong and coherent research base for recovery communities, services, and the lived experiences of recovery advocates and champions.

## Conclusion and Next Steps

The assessment of internal and external assets to support recovery maintenance has major clinical import for addiction professionals in the following areas:

- Identifying people who may resolve alcohol and drug problems without professional intervention
- Determining level of care placement
- Formulating counseling strategies
- Identifying the scope of needed ancillary services
- Constructing personal-, family-, and community-influenced plans for posttreatment monitoring and recovery support

Future efforts will focus on an expanded menu of sophisticated instruments capable of a more rigorous assessment of family and community recovery capital—tools that will also be of great value to addiction professionals and other recovery support specialists.

### About the Authors



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**Purpose**: Citizenship science is an emerging framework (National Academies of Sciences, Engineering, and Medicine, 2018) that has been embraced by addiction scholars to advance the definition of recovery. Recovery has been conceived as a lifestyle characterized by sobriety, personal health, and citizenship (Betty Ford Institute Consensus Panel, 2007) but the nature and prevalence of acts of citizenship (e.g., working towards the betterment of community such as charitable donations or receiving a promotion) in recovery are not well known. This study provides the first national prevalence estimates of citizenship acts that occurred *after* resolving a problem with alcohol or opioid use.
**Method:** An online survey, which included 12 acts of citizenship that occurred during recovery was administered to a probability-based sample of the general population of US adults (*N*=25,229) who once had a problem with alcohol or drugs and no longer do (*n*=2,047; the National Recovery Study, 2016) as part of a larger battery.
**Data**: Logistic regression analyses examined the association between primary substance (i.e., alcohol or opioid) and prevalence of acts of citizenship after adjustments. Results: Individuals who resolved a problem with alcohol or opioids were equally as likely to achieve 9 of the 12 acts of citizenship. In contrast, the opioid group compared to the alcohol group was more than twice as likely (AOR=2.12, 95% CI=1.1, 4.3) to endorse *help support my family* (45.4%, SE=.08; 30%, SE=.02), almost two and half times as likely (AOR=2.4, 95% CI=1.2, 5.0) to have *voted* (43.5%, SE=.08; 29.0%, SE=.02), and nearly 3.5 times as likely (AOR=3.4, 95% CI=1.8, 6.6) to have *helped others who were having problems* (54.2%, SE=.07; 30.3%, SE=.02).
**Conclusions**: The results are in contrast with previous research that found considerable disadvantage in terms of quality of life and building recovery capital for people in early recovery from opioids compared to alcohol. Early age of onset for opioid problems (13.1) versus alcohol (14.9) may have precluded the opioid group from acts of citizenship earlier in life and recovery is making those achievements possible for the first time. Research is needed to understand the impact of citizenship on ongoing personal remission and quality of life as well as on the community.

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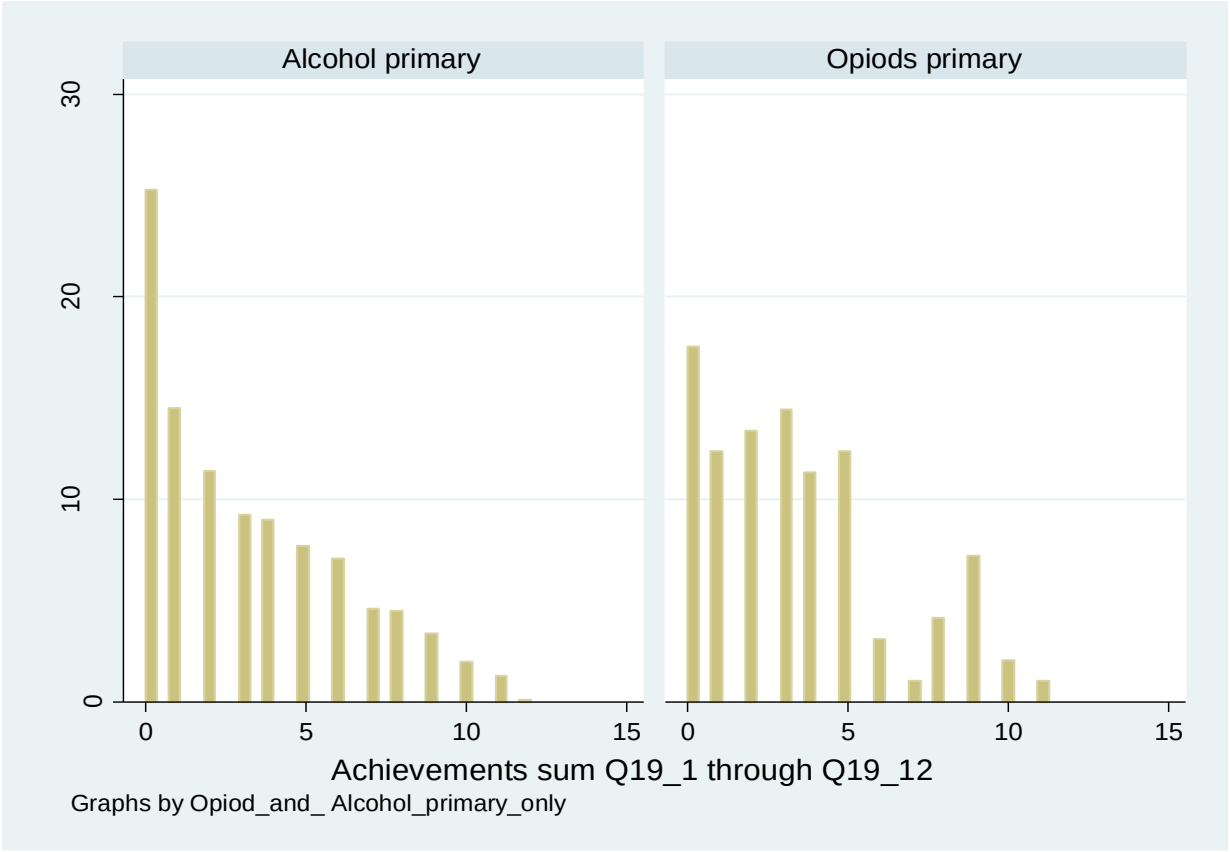
Total score of Acts of Citizenship (range 0-12) by Primary Substance




Mean number of achievements
Opioid = 3.1893
Alcohol = 2.7531
MJ = 3.07526
Other = 3.49633

Items (highlights significant)
Q19_1 Promotion in my old job NS
Q19_2 A new job NS
Q19_3 Returned to school NS
Q19_4 Completed technical school, college degree, or graduate degree NS
Q19_5 Bought a new car NS
Q19_6 Purchased a home NS
Q19_7 Helped financially support my family, significant 2.12 times as likely CI 1.047, 4.29
Q19_8 Regained custody of my children NS
Q19_9 voted, significant 2.402 times as likely to vote CI 1.14, 5.03
Q19_10 Contributed to charities NS
Q19_11 Helped other who were having problems, significant 3.439 times as likely CI 1.806, 6.550
Q19_12 Did volunteer service in my local community NS



# 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**: Galanter, M, White, W. L., & Hunter, B. D. (In Press, 2019). Cross-cultural applicability of the 12-Step model: A comparison of Narcotics Anonymous in the USA and Iran. *Journal of Addiction Medicine*. Posted at **www.williamwhitepapers.com**

## Cross-cultural Applicability of the 12-Step Model: A Comparison of Narcotics Anonymous in the USA and Iran

### Abstract

**Objective**: Narcotics Anonymous (NA), a nonprofessional 12-step fellowship for people seeking recovery from addiction, reports 27,677 meetings in the USA, where it was founded, but there is limited literature on its adaptability cross-culturally. We studied NA within the Islamic Republic of Iran to ascertain its relative adaptation in a different cultural setting.

**Method**: We surveyed 262 NA members in Iran, supplemented by member interviews, and compared demographic and substance use related characteristics of members, and also the nature of their respective involvement in NA, to the survey results of a previous US survey.

**Results**: NA in Iran reports 21,974 meetings. The Iranian respondents surveyed differed relatively little (d<0.50) from US members on demographics and prior ambulatory substance use disorder treatment, but did have fewer female members (means for Iran and US: 42.4 vs 39.0 years; 77% vs 87%; 6% vs 28%, respectively). They were, however, more involved in the fellowship (d>0.50) in terms of reporting service as sponsors, experience of spiritual awakening, and achievement of diminished craving (scores of 1–10) (85% vs 48%; 95% vs 84%; 1.03 vs 1.89, respectively). Surveyed NA members in Iran publicized the fellowship with public (36%) and religious (20%) figures, and systematically worked the 12 steps in large sponsor-led groups (X =19 members).

**Conclusion**: NA, a 12-step program developed in a Western, predominantly Christian-oriented country, was adapted widely in the Islamic Republic of Iran, a setting different in culture, language, ethnicity, and religious orientation. The growth in its membership derives, in part, from specific innovations that may have broader applicability in other settings.



# Selected Papers of William L. White

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

**Citation**: Eddie, D., Greene, M. C., White, W. L., & Kelly, J.F. (In Press, 2019) Medical burden of disease among individuals in recovery from alcohol and other drug problems in the United States: Findings from the National Recovery Survey. *Journal of Addiction Medicine*.
Posted at www.williamwhitepapers.com

## Medical Burden of Disease among Individuals in Recovery from Alcohol and other Drug Problems in the United States: Findings from the National Recovery Survey

### Abstract

**Objectives**: The medical sequelae of alcohol and other drug (AOD) problems exact a prodigious personal and societal cost, but little is known about the specific prevalence of such medical problems and their relationship to quality of life and indices of well-being among those recovering from problematic AOD use. To better characterize the lifetime physical disease burden, this study investigated the prevalence of medical conditions commonly caused or exacerbated by excessive and chronic AOD exposure in a nationally representative sample of U.S. adults in AOD problem recovery. Comparisons were made to the general U.S. population. Demographic and clinical correlates of disease prevalence were also investigated along with the relationship between distinct medical conditions and indices of quality of life/well-being.

**Methods**: Cross-sectional nationally-representative survey of the U.S. adult population who report resolving an AOD problem (n= 2002). Weighted lifetime prevalence of common medical conditions were estimated and compared to the U.S. population. Demographic and clinical correlates of medical conditions, as well as overall disease burden, were estimated using logistic regression. Results: Relative to the general population, prevalence of hepatitis C, chronic obstructive pulmonary disease, heart disease and diabetes were elevated. Likelihood of having a lifetime diagnosis of a specific disease was related to primary substance used and sex. Quality of life was lower among those with physical disease histories relative to those without.

**Conclusions**: Findings highlight the increased medical burden associated with AOD problems, and speak to the need for earlier and more sustained intervention for AOD problems, greater integration of addiction treatment and primary health care, and longitudinal research to explore the complex, dynamic relationships between AOD use and physical disease.

**WORKING DRAFT**
**(March 6, 2019)**

# POTENTIAL ROSC MEASURES FOR CHILDREN, ADOLESCENTS, TRANSITION AGE YOUTH, AND FAMILIES (CATAYF)

**William White, MA, Michael Flaherty, PhD, & Precia Stuby, MSW**

## Introduction

The recovery oriented systems of care (ROSC) framework has been effectively used to transform acute and palliative care approaches to behavioral health disorders to models of assertive and sustained recovery management, but efforts to extend this framework to the transformation of services for children, adolescents, transition age youth (age 16-25), and families (CATAYF) remain at an early developmental stage. The below table was created by the Hancock County Board of Alcohol, Drug Addiction, and Mental Health Services as it explored options to extend its ROSC development efforts to include research-grounded CATAYF service initiatives and CATAYF-specific system performance measures. We hope it will be helpful to other communities as they embark on similar initiatives. The table begins with A CATAYF General category of ROSC initiatives and measures that apply across CATAYF populations and then proceeds to look at key research findings, potential interventions, and potential clinical and systems performance measures for each population. Our goal was not to review all CATAYF research but rather to draw upon actionable CATAYF research findings—studies with the most significant implications for CATAYF service practices and systems of care performance measures. Communities may select from this extensive menu of potential performance measures those key measures most suitable to their systems of care and current data collection capabilities.

**Special Acknowledgements**: We would like to acknowledge the special contribution of Dr. Ralph Tarter, PhD, Director of the Center for Education and Drug Abuse Research, for his preparation of a briefing paper that we found exceptionally helpful in summarizing scientific research on key aspects of the heritability of substance use disorders and the effects of parental SUDs on child development. Where excerpts from the Tarter briefing paper are included and cited below, “Tarter, 2019” indicates a quoted excerpt and any citations that follow it are the citation included in the briefing paper.

**Funding Acknowledgement**: This work was supported in part by Health and Human Services, Substance Abuse and Mental Health Services Administration System of Care Grant SM80141 awarded to Hancock County, Ohio ADAMHS. The system of care grant awarded to the Board in 2018 provides the opportunity to expand the implementation of ROSC to youth and their families. In order to monitor and measure success, it is essential that our efforts are grounded in the most current research related to treatment, interventions, and performance measures. The contents of this document summarize this information and will guide our efforts moving forward.

**Acronyms used within the table include the following:**

**AA** Alcoholics Anonymous

**ACC** Assertive Continuing Care

**ACE** Adverse Childhood Experiences

**AOD** Alcohol and Other Drugs

**ARC** Assessment of Recovery Capital

**ASAM** American Society of Addiction Medicine

**ATAYF** Adolescents, Transition Age Youth & Families

**AUD** Alcohol Use Disorder

**BARC** Brief Assessment of Recovery Capital

**CAC** Consumer Advisory Committee

**CATATY** Children, Adolescents, Transition Age Youth, and Families

**CDI** Child Directed Intervention

**CJ** Criminal Justice

**CWS** Child Welfare System

**CRAFT** Community Reinforcement & Family Training

**CYF** Child Youth Family

**DSM** Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association

**EBT** Evidence-based Treatment

**EO** Early Age of Onset

**E-Recovery** Electronic (computer/phone/tablet) based Recovery Support Services

**FASD** Fetal Alcohol Spectrum Disorder

**FI** First Intoxication

**F-2-F** Face-to-face

**GAIN** Global Appraisal of Individual Need

**H-RQoL** Health-related Quality of Life

**IFC** Intensive Family Coaching

**LGBTQ** lesbian, gay, bisexual, transgender, queer, or questioning

**MAT** Medication Assisted Treatment

**MH** Mental Health

**NA** Narcotics Anonymous

**NAS** Neonatal Abstinence Syndrome

**OD** Overdose

**OUD** Opioid Use Disorder

**Q & A** Question and Answer

**QoL** Quality of Life

RMA Recovery Mutual Aid

**REBM** Relationship Enhancement and Behavioral Management

**ROSC** Recovery oriented System of Care

**SED** Severe Emotional Disturbance

**SMART** SMART Recovery

**SMI** Serious Mental Illness

**SUD** Substance Use Disorder

**TAY** Transition Age Youth

**Tx** Treatment

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
|---|---|---|---|---|
| **CATAYF** | **Representation:** CATAYF | Assure CATAYF involvement in | CATAYF Consumer | CATAYF and peer inclusion |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
|---|---|---|---|---|
| **General** | services have until recently been designed, delivered, and evaluated without the direct involvement of CATAYF representatives (White et al., 2002) | the planning, design, conduct, and evaluation of prevention, early intervention, treatment, and post-treatment recovery support services.<br><br>Assure inclusion of local CATAYF service agencies and peers in planning & evaluation processes | Advisory Committee (CAC)<br><br># CAC advisory meetings<br><br># CATAYF volunteers | in Governance Board and service committees<br><br># of funded agencies with CATAYF Consumer Advisory Committees |
| **CATAYF General** | SUD Vulnerability in General Population "Over 90% of the U.S. population use an addictive substance at least one time. Approximately 85% of the population do not develop SUD. In the residual population, substance use is prodromal to development of a SUD" (Tarter, 2019).<br><br>"Large scale epidemiological studies … convincingly demonstrate approximately half the variance (source of causation) in SUD is genetic" (Tarter, 2019; Kendler et al., 2003). | Community-wide prevention and education programs that convey risk factors for SUD development and recovery support resources for individuals and families. | Clinical measures to distinguish transient, low severity AOD problems from SUDs of high severity, complexity and chronicity requiring sustained and assertive recovery management | Community measures of AOD use, AOD-related problems, and AOD problem resolution across the spectrum of problem severity<br><br>Number of family screens for heritable or other risk<br><br>Based on these screens, # of derived child or family interventions for education, prevention or relationship enhancement and wellness<br><br>Number of linkages to |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
|---|---|---|---|---|
| | | | | recovery supports |
| **CATAYF General** | **Recovery Prevalence & Pathways** Recovery prevalence and quality of life in recovery can be measured through national (Kelly et al., 2017) and local community surveys (White et al., 2013)<br><br>Multiple pathways & styles of adult SUD recovery are being mapped (Flaherty et al, 2014; Zemore et al., 2016; Kelly et al., 2017) but such variations have yet to be charted specifically for adolescents, TAY, and families. | Include CATAYF relevant recovery and quality of life measures within local health survey<br><br>Among individuals with any prior SUDs, compare local data with following national prevalence data for past-year substance use and DSM-5 symptomology: abstinence (14.2%), asymptomatic use (36.9%), symptomatic use (10.9%), and persistent/recurrent SUD (38.1%) (McCabe et al., 2018). | Ensure availability of a system and continuum of care for CATAYF<br><br>Provision of normative data on recovery prevalence, pathways, and recovery QoL to service consumers<br><br>Linkage relationships with service committees of secular, spiritual, & religious recovery mutual aid groups and recovery community organizations | ASAM Continuum of care for CATAYF populations is existent<br>Baseline and annual or biennial recovery prevalence rates across CATAYF populations<br><br>Map CATAYF recovery support pathways / changes over time<br><br># of workforce trainings on multiple pathways of recovery and ROSC conceptual alignment<br><br>Independently report CATAYF data to community & service consumers to reduce SUD misconceptions and related stigma |
| **CATAYF General** | **Service Attraction & Access** CATAYF encounter special obstacles in accessing SUD treatment and recovery | Provide CATAYF-specific outreach services and a One-Stop or centralized access point for services | Documentation of contact frequency and successful CATAYF | Incidence of stigma & other barriers to service initiation; rates of service utilization; |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
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| | support resources, including negative perceptions of treatment, fear of social stigma attached to SUDs, lack of insurance or ability to pay, lack of CATAYF-specific services, lack of existing CATAYF representation in recovery support groups, and transportation issues (van der Pol et al., 2013; Liebling et al., 2016). | Conduct public education and prevention events aimed at reducing SUD and stigma for CATAYF populations<br><br>Encourage development of CATAYF recovery support groups and E-recovery support services (youth friendly online groups, virtual alternative peer groups, web- and mobile-based recovery apps, etc. | service/support linkage; improved service access for CATAYF population<br><br>% of admitted clients with no prior service history<br><br># monthly hits on website; # hits on screening pages | # of sponsored public education/prevention/early intervention events<br><br>Average time from service request to service delivery across funded agencies<br><br>% of people on waiting list prior to service initiation; average time on waiting list |
| | There are populations with special needs who face unique obstacles to accessing needed treatment, e.g., women with opioid use disorder (Patrick et al., 2018) | Provision of interim support services for people on waiting list for service<br><br>Provide problem screening instruments, service Q & A & service reviews on agency website | Average time from service request to service delivery | % of CATAYF receiving at least one recovery support service within 7 days of contact<br><br>% of people retained between 1st and 2nd appointment |
| | Populations of people with SUD/SED/SMI who are recycling through emergency medical services without linage to appropriate services | Implementation of Recovery Management Checkups in Primary Care (RMC-PC) protocol | #of SUD, MH and Trauma screens<br><br>Average time from problem assessment | Appropriate clinical matching and changes in level of care placement exist and are used over time |

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| | and with high mortality risks (Urbanoski et al., 2018). Assertive SUD screening and linkage within primary care increases SUD treatment admissions, treatment duration, and post-treatment recovery outcomes (Scott et al., 2018) | Inclusion of family or advocate in all services | to initial service contact | # of CATAYF recovery support meetings<br>Average time from problem onset to initial recovery support linkage<br><br>% of SUD admissions from health care providers |
| | Online recovery support resources can provide increased access to CATAYF recovery support resources (Molfenter et al., 2015; Liang et al., 2018) especially for marginalized populations (e.g., LGBTQ youth, Allen et al., 2016). | Expand available electronic clinical/recovery support tools<br><br>Educate community and clinical CATAYF populations on available E-recovery support services and tools | # hits on agency website for links to e-recovery support resources | # outreach hours per month/quarter<br><br>Continued use of Cultural and Linguistic Specialist for system of care consultation<br><br># of bi-lingual staff and volunteers working within the system of care |
| | Clinical populations with a family history of SUD/SEM/SMI problems constitute special populations that may require increased pre-treatment efforts to enhance readiness for change (Kibitov et al., 2018) | Potential use of outreach workers & recovery coaches to enhance readiness for clinical services<br><br>CATAYF-specific outreach efforts in schools, youth serving agencies, allied health | # of service admissions resulting from outreach contacts<br><br># of service admissions resulting from CATAYF at risk | Changes in admission of underserved populations |

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| | Assertive peer outreach workers can engage adult active opioid users with successful linkage to treatment (Scott et al., 2018), but this intervention has not yet been tested with adolescent opioid users. Peer recovery support services are becoming an integral component of the behavioral health care system (Myrick et al., 2016; Davidson et al., 2012; White, 2009), but research related to CATAYF-specific peer services is extremely limited at present. | agencies, and allied systems (e.g., criminal justice, child welfare)<br><br>Assure culturally and linguistically competence outreach and service provision<br><br>Formulate marketing plan to reach underserved populations that includes social media and culturally-mediated communication channels | outreach contacts<br><br># of bi-lingual staff & volunteers<br>Change in admission rates, demographics of underserved populations<br><br>% of family/advocate involvement | |
| **CATAYF General** | **Assessment & Service Planning**<br>The pattern of adolescent and TAY substance use is most often one of multiple substance use over time, suggesting the limitation of any intervention focusing on one substance **(**Merrin et al., 2018) | System-wide Integration of global versus categorical assessment instruments (e.g., Global Appraisal of Individual Need/GAIN).<br><br>Shift from deficit-based to strengths based assessment protocol using such instruments as the Assessment | % of clients assessed at mild to moderate problem severity levels (# DSM SUD symptoms)<br><br>Documented use of recovery capital measures within | Average problem severity (# DSM SUD symptoms) and recovery capital scores of persons entering system of care<br><br>#training/consultations related to strengths-based assessment & service planning |

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| | | of Recovery Capital (ARC, Groshkova et al., 2012), Brief Assessment of Recovery Capital (BARC, Vilsaint et al., 2017), or Rapid Recovery Progression Measure (RRPM, Elison et al., 2017). | clinical supervision | Family/advocate involvement |
| | Integrated SUD/SED/SMI assessment, service planning & delivery with ancillary services increase recovery outcomes compared to parallel of sequential treatment (Wolitzky-Taylor et al., 2018) | Continue to pursue service integration efforts and experiments in co-location of service delivery.<br><br>Include all systems in service delivery, e.g. Court, CYF, CJ.<br><br>Marketing of CATAYF services to primary care physicians/pediatricians, assistants, practitioners, nurses | Percentage of clients receiving the following: Case management, transportation, day care, housing, financial counseling, educational services, vocational services, legal counseling<br><br>#/% of new clients referred from primary health care resources<br><br>#/% of clients provided or linked to primary care services | # of formal and active cross-sector service integration projects<br><br># of clients/families in cross-sector services linked to recovery supports<br><br>#/% of new clients referred from primary health care resources |
| **CATAYF** | **Optimal Service Duration** A | Test strategies that can | Average service | CATAYF service completion |

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| **General** | major concern related to SUD treatment is the percentage of people who begin but do not complete a course of treatment (over 50%)(White, 2008)<br><br>Recovery outcomes increase if recovery support is maintained across levels of care for at least 90 days (NIDA, 2018) | enhance service retention, e.g., warm welcome techniques, motivational interviewing training, peer coaching, contact following missed service appointments, managed care (case management)<br>Provide continuity of recovery support across levels of care transitions. | duration by demographic and clinical profile<br><br>CATAYF service completion rates by program and population<br>% of people in detox and IOP/residential care successfully linked to lower levels of care | rates by program<br><br>% of people served in residential and/or outpatient modalities for at least 90 days across levels of care.<br>#/% of persons served readmitted to care within 90 days of discharge<br><br>% of CATAYF served who report positive service satisfaction at conclusion of primary treatment<br><br>Days/costs of inpatient/residential care for whole system<br><br>% of people admitted to care with prior treatment admissions (tracking desired reductions across time) |
| **CATAYF General** | **Post-treatment Monitoring & Support** Post-treatment SUD recurrence is common (See | Provide a clinically-titrated schedule of post recovery checkups (monitoring, | # of follow-up call attempts and connections | % of CATAYF receiving follow-up contact within 14 days of clinical service |

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| | White, 2008) but can be reduced via post-treatment recovery support (Dennis & Scott, 2007);<br>Early post-treatment SUD recurrence is associated with increased mortality risk (Kline-Simon et al., 2017) | support, early re-intervention if & when needed), with high intensity in first 90 days following discharge, followed by quarterly and annual checkups thereafter. | #/% of clients who receive at least 6 recovery checkups in first 90 days following cessation of clinical services | cessation<br><br>% of CATAYF receiving warm handoffs to continuing, uninterrupted care |
| | Emotional health may decline in early months of recovery before increasing (Kelly et al., 2018); period of peak emotional distress in SUD recovery appears a few years into the recovery process (Dennis et al., 2007)<br><br>SUD recovery is not fully stabilized until 4-5 years of continuous recovery (See White, 2008).<br><br>Stressful life events constitute a major barrier to SUD remission stability and warrant increased recovery support (McCabe et al., 2016) | Sustain telephonic or e-recovery support checkup on at least an annual basis for five years from point of service discharge.<br><br>Offer/suggest increased frequency of recovery support contact when major stressors are identified within recovery check-ups<br><br>Independently monitor rates of CATAYF continuing care /recovery checkup contacts | #/% of clients who report recovery mutual aid group attendance in past month<br><br>#/% of clients reporting volunteer or sponsorship contact in last week<br><br>Rates of service re-admission in year following discharge | % of people admitted to same or higher level of care in 90 days and year following discharge<br><br>#/% of clients within funded agencies who receive at least 6 recovery checkups in first 90 days following cessation of clinical services<br><br>% of clients receiving at least annual recovery checkups for 5 years following last service appointment |

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| | Post-treatment continuing care reduces the rate of readmissions following treatment discharge (Reif, Acevedo et al., 2017) | Provide high intensity F-2-F outreach and telephonic contact with adolescents and TAY who disengage from MAT. | | |
| | Youth in medication assisted treatment are at increased risk of early drop out and warrant focused follow-up and re-engagement (Samples et al., 2018) Drop-out rates from methadone maintenance treatment range from 46-65% within a year of admission (Lo et al., 2018)<br><br>CATAYF recovering from co-occurring SUD/SED/SMI are at increased risk of ongoing challenges and benefit from sustained monitoring and support (Kronenberg et al., 2015) | Integrated SUD/SED/SMI recovery checkups and recovery planning review | % of adolescents and TAY who drop out of MAT who are assertively linked to recovery support services<br><br>Reporting of Continuing care data for CATAY with co-occurring disorders<br><br>Linkage to family and/or peer support | Rates of service re-admission in year following discharge<br><br>Mortality of adolescents & TAY within 90 days of MAT dropout. |
| | **Reducing Mortality Risks** For people recovering from an opioid use disorder, there is | Provide increased monitoring and support during service transitions and terminations. | Number of deaths from drug-related incident during | Quarterly reporting of deaths during or immediately following |

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| | increased risk of death during transitions, e.g., release from incarceration, moving between levels of SUD care, and immediately following service termination (Pizzicato et al., 2018: Johnson et al., 2005; Scott et al., 2011).<br><br>People who survive a drug overdose are at significantly increased risk for death in the following 12 months related to diverse substance, psychiatric, and medical conditions (White, 2018; Olfson et al., 2018)<br><br>Mortality risks following a non-fatal opioid overdose decline with admission to medication assisted treatment (Larochelle et al., 2018)<br><br>The visibility of opioid overdose deaths belies the dominant pattern of | Conduct follow-up contacts within 30 days of discharge regardless of discharge status<br><br>Require reports of all deaths during & immediately following treatment. Conduct reviews of each for system improvement.<br><br>Provide enhanced frequency of recovery checkups with depression screen for those in high risk cluster<br><br>Peer-based recovery supports provided through emergency services and hospital emergency rooms with linkage to treatment and recovery support resources (Waye et al., 2018). | treatment or within 30 days of service termination<br><br>Documentation of critical incident debriefing on deaths within 90 days of Tx discharge<br><br>% of assessed ER overdose patients linked to MAT or RMA group<br><br>% of opioid admissions with multiple SUDs<br><br>% of alcohol hospitalizations linked to follow-on treatment<br><br>% linked to peer support | treatment<br><br>Overdose deaths incidence and demographics<br><br>OD survival rate<br><br>% of OD patients linked to “warm handoffs” and service within 7 days of emergency incident<br><br>% of assessed ER overdose patients linked to MAT<br><br>% of MAT patients linked to peer supports<br><br>Percent of opioid-affected CATAYF also meeting criteria for other SUDs/SED/SMI |

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| | polysubstance use & deaths from multiple drug interactions (Jalal et al., 2018). The majority of persons diagnosed with a SUD meet criteria for multiple SUDs (McCabe et al, 2017).<br><br>Persons are at increased risk for suicide following an alcohol-related emergency hospitalization (Bowden et al., 2018) | Prevention, Harm reduction), early intervention, treatment and recovery support services focus on all patterns of substance use and addiction rather than substance-specific interventions.<br><br>Include depression screens within ER interventions and follow-up contacts with assertive link to psychiatric care a& RMA groups as indicated. | % of persons served with both past OD & suicide attempt | # of community overdoses and overdose deaths<br><br>Existence of a community strategic plan to address and prevent OD and Suicide<br>Reported suicide attempts/deaths |
| **CATAYF General** | **Health-related Quality of Life (H-RQol) in Recovery** CATAYF experiencing remission from SUD/SED/SMI experience improved H-RQol and lower health-related costs (Kelly et al., 2018; Laudet, 2013) but continue to experience lower H-RQol than the general population (Rubio et al., 2013; White et al., 2013). | Screening of all behavioral health care (BHC) clients for primary health care problems.<br><br>Assertive provision or linkage of BHC clients for primary health care problems<br><br>Increase integration of behavioral health care and primary health care<br><br>Co-location of BHC and PHC | % of clients screened for primary health care problems<br><br>% of SUD/SED/SMI clients with chronic primary health disorders; % of clients using ER or inpatient hospital services in past year for primary health care issues; % of clients referred for | ER and inpatient hospitalization rates before & following service provision |

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| | | services | primary health care services | |
| | Much of compromised H-RQol and related mortality is linked to high rates of concurrent tobacco dependence (Hirsch, 1995); Smoking cessation increases SUD recovery rates and related H-RQoL (Prochaska et al., 2004). | Integrate smoking cessation support into SUD/SED/SMI treatment' include vaping, juuling | % of clients who are regular tobacco et al users at admission<br><br>% of clients who are regular tobacco et al users at discharge & follow-up | % of funded programs offering smoking et al cessation services |
| **CATAYF General** | **Service Team Composition**<br>Research to date on peer-based recovery support services suggest that such services can enhance long-term SUD/SED/SMI recovery outcomes (Bassuk et al., 2016; Reif et al., 2014; Repper et al., 2011; White, 2009) and may have particular utility within the child welfare system (Ryan et al., 2016; Ryan et al., 2017). | Increase CATAYY-focused peer recovery support services, including volunteer peer recovery support networks for adolescents, TAY, and families; create continuum of peer services across combinations of co-occurring conditions and CATAYF with special needs<br><br>Integrate paid peer recovery support specialists within multidisciplinary professional service teams<br><br>Create peer council representing this diversity of | Average client/counselor ration<br><br>Quarterly # of volunteers and volunteer hours<br><br>#/percentage of clients receiving peer recovery support services | Quarterly # of volunteers and volunteer hours<br><br>#/% of CATAYF receiving peer recovery support services<br><br># of people in catchment area certified as peer recovery support specialists<br><br># of paid peer positions |

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| | | needs to generate service design and implement recommendations | | |
| **CATAYF General** | **Service Relationship**<br>Therapeutic alliance is a key factor in service retention, a primary mechanism of change within the service process, and the primary factor in service satisfaction (de Giorgi et al., 2018; Vernmark et al., 2018; Karver et al., 2018). | Staff training in motivational interviewing<br><br>Formally measure & track service engagement rates by program and by worker<br><br>Review administrative discharge policies | Average therapeutic alliance ratings over time within client service evaluations<br><br># of client grievances<br><br>% of positive urine screens during treatment<br><br>#/% of administrative discharges<br><br>Peer telephonic post-treatment evaluation ratings with re-linkage when needed | Systems level client retention data, i.e. 90 days, 6 months, 1 year |
| **CATAYF General** | **Locus of Service Delivery**<br><br>Assertive outreach efforts are recommended to reach the majority of adolescents and TAY with SUDs/OUDs who do not seek SUD/OUD treatment | Extend face-to-face service delivery into natural environments of those served<br><br>Expand E-recovery support services across the stages of | #/% of services offered outside of agency service facilities | # of outreach programs<br># of outreach service contacts<br># of co-location pilots |

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| | (Wu et al., 2016; Carmona et al., 2017; Guo et al., 2017).<br><br>Online recovery support technologies provide an effective means of expanding service reach beyond service facilities (Bergman et al., 2018) but these new technologies have to date focused primarily on adults (Fowler et al., 2016) | recovery | # of E-Recovery support contacts | #/% of funded agencies offering specialized CATAYF E-recovery support services |
| **CATAYF General** | **Recovery Landscape/Space**<br>There has been a recent increase in the development of new recovery support institutions and ecological models of community-focused prevention and recovery support e.g. recovery support groups, recovery residences, recovery industries, recovery ministries, recovery cafes, recovery celebration events, etc. (White et al., 2012; Ashford et al., in press) | Volunteer and paid positions focused on recovery community resource development<br><br>Encourage development of CATAYF services within new recovery support institutions | Ecological assessments included within assessment data and service planning<br><br>% of staff who have attended a local recovery support group in past month | Number of CATAYF recovery support groups/meetings<br><br>#/capacity of recovery homes that accept parents and children.<br><br>Annual recovery resources mapping survey noting the number of CATAYF-inclusive recovery support institutions |

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| | Increased ethnic/cultural identity can serves as a protective factor against SUD development and recurrence (McCarron et al., 2018; Carter et al., 2018; White & Sanders, 2008) | Support ethnic cultural revitalization movements that address health and relationship challenges within the contexts of historical trauma and needed personal/cultural renewal. Engage culturally indigenous leaders and institutions in CATAYF service planning and delivery. | % of staff trained in cultural competence & cultural pathways of recovery<br><br>Client/family measures of improved recovery capital | Cultural diversity within all governance, planning, and clinical advisory committees<br><br>Ethnicity of CATAYF service admissions |
| **Children** | **Child Mortality** Accidental opioid poisoning of children and related deaths have increased in tandem with opioid prescribing and the expansion of medication-assisted treatment of opioid addiction (Gaither et al., 2016; Finkelstein et al., 2017; Allen et al., 2017). The 8,986 deaths of children and adolescents from opioid poisoning in the U.S. between 199 and 2016 marks a 3-fold increase in the mortality rate. This includes 605 of children aged 0-4 (Gaither et al., 2018). Nearly | Multimedia community and professional education on risks to children, appropriate medication storage, and timely and proper medication disposal.<br><br>Verbal warning and pamphlet insert with all opioid prescriptions on dangers of opioid poisoning in children. | Quarterly # of presentations<br><br>Quarterly # of media info disseminations via newspaper, TV, Social Media | Quarterly/annual # of drug poisoning deaths among children<br><br># of screens and educational presentations to families and children on effects of all SU, including parental-child bonding and impact on short and term child development |

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| | 5,000 children are evaluated for opioid poisoning in U.S. annually in emergency departments (Lovegrove et al., 2018. In addition to opioid poisoning, parental addiction creates adverse experiences for children through opioid misuse during pregnancy, impaired parenting, weakened attachment, material deprivation, and extended separations between parents and children (Feder et al., 2018). | | | |
| **Children: Gestation Period** | Fetal development is linked to good nutrition, absence of toxic chemicals, drugs, alcohol and infection and emotional regulations of mother. (Behnke, 2013, Chapman et al., 2007)) | Insure health of mother during pregnancy; pre-natal examinations | Assess physical and psychological health of mother and family | # of women receiving complete physical and psychological assessments<br><br># of women connected to treatment<br><br># of women connected to peer supports |
| **Neonatal Period** | The first month after birth is critical for establishing parental caregiving practices | Assess capabilities and limits of mother and home life, support | Measure of quality of relationship between child and mother and | Develop quality measure for family that includes recovery capital |

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| | and social support (Tarter, 2019) | Provide parenting training with SU treatment (if needed) | home<br><br>Delivering hospital is aware, in advance of delivery, of SU and Tx History of mother | development, peer support<br><br>% of parents provided parenting and peer support<br><br>% of babies born with SU related comorbidity or mortality |
| | **Fetal Alcohol Spectrum Disorder (FASD)** is linked to increased risk for early onset AOD use and related problems, increased risks for adult substance use disorders, mood disorders, and neurocognitive impairments (Grant et al., 2013). | Host panel to review continuum of care for alcohol and drug-exposed infants, e.g., screening at-risk mothers, scoring systems for pre-natal care involvement, neonatal drug withdrawal, type and duration of pharmacotherapy, and post- discharge monitoring and support | Staff Review of panel recommendations<br><br># parent education sessions on FASD & NAS in community & clinical settings | Quarterly/annual incidence of reported FASD & NAS<br><br># FASD & NAS community training sessions<br><br># of pre-natal care visits among service-enrolled mothers |
| | **Neonatal Abstinence Syndrome (NAS)** The incidence of (NAS) has increased in tandem with the opioid epidemic (Pryor et al., 2017). | Conduct screenings for (FASD) and Neonatal Abstinence Syndrome (NAS) for all persons entering addiction treatment and integrate accommodations for the potential | # of joint client | # FASD/NAS info brochures disseminated to service consumers & public<br><br>#% of parents in child welfare system due to |

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| | | cognitive/behavioral deficits such individuals may exhibit that could compromise their long-term recovery outcomes. | service planning meetings<br>% of pregnant women in treatment receiving prenatal care, sustained monitoring, & support | substance-related neglect/abuse receiving SUD services |
| | Cross-sector service planning and integration increase the number of pregnant women seeking services for SUDs (Kozhimannil et al., 2018) and enhance parent retention in treatment, parental SUD recovery, and parent retention of child custody (Huebner, Posze et al., 2015). | Provide information to parents on long-term effects of FASD and NAS and parental management strategies. | | #% of women in service who retain custody of their children |
| | | | # of parents participating in parenting in recovery classes as part of treatment or continuing care | Average # of pre-natal visits of pregnant mothers within funded agencies |
| | “Fetus exposure to addictive drugs, toxic chemicals, infectious microbes, and stress hormones interact with genotype in myriad complex ways to influence future SUD risk before birth.” (Tarter, 2019) | Cross-agency joint service planning | | # of parents participating in parenting in recovery classes as part of treatment or continuing care |
| | | | | # of parents connected to a peer support service |
| | “Neonatal abstinence syndrome (gastrointestinal distress, disturbed sleep, irritability, etc.) severely challenges maternal caregiving.” (Tarter, 2019)“ | Parental coaching for new parents/mothers in recovery from opioid addiction. | | % of births with severe SU related comorbidity or mortality n infant |
| | “Difficult temperament (e.g., intense emotionality, irregular | | | |

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| | sleep rhythms, fussiness, irritability) is more frequent in offspring of SUD parents." (Tarter, 2019; Horner et al., 2015; Caspi et al., 1995) | | | |
| **Children Infancy** | Difficult temperament (e.g. intense emotionality, irregular sleep rhythms, fussiness, irritability) is more frequent in offspring of SUD parents (Horner, 2015). | Assessment of parental competence, recovery and investment in parenting | Integrate ongoing parenting support with SU Tx and recovery plan | % of families receiving parenting of infants training with SU tx<br><br>% of linkage to peer supports |
| | Early Development and Developmental Delays Infants of methadone-prescribed opioid-dependent mothers exhibit poorer neurodevelopmental difficulties for the first six months compared to controls (McGlone & Mactier, 2015). | Linkage of mothers/infants for specialized support services. | % of patients & infants provided post-discharge monitoring for at least 6 months.<br><br>% of new mothers in MMT who receive parental education and coaching | % receiving parenting-focused services |
| | Toddlerhood is a critical period for acquiring habits of sharing and cooperative play, extinguishing norm-violating behaviors (e.g., hitting, biting), internalizing pro-social values, and using language for | Develop parenting in recovery training curricula for integration in treatment and as a post-treatment recovery support service | # of parents completing parenting in recovery training<br><br>Continue measurement of relationship and | # of parents completing parenting in recovery training<br><br># of parents linked to Peer Support or Intensive Family Coaching (IFC) |

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| | emotional self-regulation, impulse control, and problem solving (Tarter, 2019; Eiden et al., 2004). | | bonding of mother/child | |
| **Children** | **Heritability Risks** SUDs are transmitted intergenerationally through a variety of genetic/biological and environmental (parent /sibling /family, peer, and community) mechanisms that vary across persons and subgroups (Vossoler et al., 2013; Kendler et al., 2003; Evans et al., 2014). Substance use Disorders (SUDs) are heritable disorders with heritability risks ranging from 39-72% (Goldberg & Gould, 2018; Enoch, 2006; Crist et al., 2018). Children of parents who have a SUD are at 4-7 times the risk of SUD development compared to children of unaffected parents (Tarter, 2019; Vanyukov & Tarter, 2000)—genetic risks that may be enhanced by | Providing targeted education, prevention and early intervention services to children of parents admitted to SUD treatment and to other children affected by parental AOD problems.<br><br>Communicating heritability risk to SUD-affected parents with info on potential youth prevention and early intervention resources, noting that SUD risk is not fixed as it varies across the child's development and through the availability of resources that enhance resistance and resilience (Tarter, 2019). | # of teaching interventions on SUD vulnerability of children | Development & dissemination of a Policy Statement on Promoting Family Recovery and Intergenerational Health (Evans et al., 2014)<br><br>Create a Council on Intergenerational Health—a multi-agency coalition committing staff and public financial resources toward joint policy and service initiatives aimed at understanding and stemming the intergenerational transmission of AOD problems, mental health challenges, child neglect and abuse, school failure, criminality, and violence (Evans et al., 2014) |

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| | prenatal alcohol exposure and adverse developmental experiences (Goldschmidt et al., 2018). "Half the variance (source of causation) in SUD etiology is genetic"; this risk of vertical SUD transmission is to a spectrum of SUDs and related behaviors rather than to a specific substance: "even though policymakers, clinicians and media focus on specific compounds as distinct societal scourges, all SUDs are variants of one disorder." (Tarter, 2019). | Service planning should focus on the broad spectrum of risky AOD use and related SUDs rather than the drug crisis of the moment. Channel present alarm about opioid addiction toward community response to full spectrum of AOD and related problems. | | |
| | "SUD Risk is greatest in children whose parents developed SUD before 30 years of age" (Tarter, 2019).<br><br>"Whereas intergenerational risk for SUD occurs in all socioeconomic strata, the greatest risk is transmitted to children domiciling in disadvantaged | Explore identifying high risk youth & families via available screening instruments, e.g., Transmissible Liability Index (TLI), Drug Use Screening Inventory Inventory (DUSI-R)(Tarter, 2019; Tarter & Kirisci, 2001 )<br><br>Provide targeted prevention and early intervention | # of children of parents in treatment who are identified as at risk for SUD development & provided prevention services | # of children of parents in treatment who are identified as at risk for SUD development & provided education and prevention services related to intergenerational risk factors and built resilience and recovery |

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| | neighborhoods" (Tarter, 2019; Ridenour et al., 2009).<br><br>The interaction of biological and environmental risk factors produces phenotypes (biological and psychological characteristics) that dramatically elevate the risk of SUD development Abuh-Saleh et al., 2017).<br><br>"It is feasible to measure intergenerational risk to identity youths requiring prevention intervention" (Tarter, 2019).<br><br>"Deploying interventions that impede genetic liability from manifesting as impaired psychological regulation and non-normative socialization is required to lower SUD risk" (Tarter, 2019; Fishbein et al., 2006) | activities to high risk children, youth, and families. | | |
| **Children** | **Developmental Problems**<br>Most (60- 75%) children of | Screening children of parents entering SUD treatment for | # of children under 13 participating in | % of CATAYF agencies routinely screening |

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| | alcohol-dependent parents will not go on to develop AOD problems (Beardless et al, 1986), but children who have experienced sustained exposure 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 (Pandina et al, 1989). Children of parents with SUDs experience increased rates of psychosocial problems which dissipate when the parent is treated for the SUD and the child has access to psychosocial supports (Burdzovic, Andreas & O'Farrell, 2017).<br><br>"Harbingers of SUD are usually detectable, such as conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD) before the | emotional distress and behavioral problems and assertively linking them to community resources to enhance resilience and health.<br><br>Provision of training to CATAYF agencies on behavioral health screening<br><br>Include physical/emotional health, AOD status and school performance of children into adult assessment and recovery check-up protocol<br><br>Appropriate access to evaluation and treatment resources for CD and ADHD, including access to medication or ADHD; development of | family/child programs as part of parental SUD treatment<br><br>Scale of child health indicators in parental post-treatment recovery checkups | children for behavioral health risks<br><br>#/% of children identified as at risk or experiencing for development of behavioral health problems<br><br>#/% of at risk children successfully linked to prevention or early intervention resources<br><br>Community-level developmental markers for children , e.g. # of identified high-risk youth; families; # of educational and prevention interventions<br><br># of families connected to Peer Support or Intensive Family Coaching<br><br>% of related families seen |

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| | child reaches ten years of age. Psychiatric disorder, particularly externalizing disorders, greatly amplify SUD risk…..Severe externalizing behavior disorder is childhood portends SUD consequent to hard illegal drugs whereas lower severity of the liability during childhood predisposes to alcohol and nicotine disorders" (Tarter, 2019; Krueger et al., 2002). | specialized CD and ADHD recovery management programs for youth<br><br>Saturated services to high risk youth, including coping and social competence and interpersonal etiquette training and access to normative socialization (Connection to pro-social groups and organizations) as well as resources to enhance academic and other areas of achievement, e.g., employment, artistic, athletic. | | kept in tact<br><br># of youth treated for CD or ADHD<br><br>Screening of all youth for family history or pre-disposing risk factors<br><br># of youth identified at risk connected to education, prevention and recovery supports. |
| **Children** | **Parent Child Relationships**<br>SUDs can produce negative effects on the parent-child relationship, though these seem to be more pronounced in Euro-American than African-American parents (Slesnick et al., 2014).<br><br>Weak parent-child bonding from low parental competence, sparse parent- | Inclusion of parenting training and coaching as an integral or adjunctive component of addiction treatment.<br><br>Assertive linkage to parental training and support resources in the community.<br><br>Explore use of parent-child assessment instruments as adjuncts to SUD treatment | # of clients/partners participating in parenting training | Rates of Substance-related child placement<br><br>Quarterly # of parenting support group meetings<br><br>% of SUD families connected to peer support groups |

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| | child communications, and inadequate supervision increases risks of psychological dysregulation, non-normative socialization, suboptimal acquisition of pro-social values and morals in the child, which in turn increases the risk of early AOD use and SUD onset (Tarter, 2019)<br><br>There is a clear but complex relationship between parental addiction, child neglect, child maltreatment, and the subsequent emotional and behavioral health of children. (Ryan et al., 2016; Dunn et al., 2002; Choe et al., 2013)<br><br>Grandparents bear an inordinate responsibility for care of grandchildren affected by parental SUD/SED/SMI. (de Toledo & Brown, 2013) | Providing parents in SUD treatment access to parenting in recovery peer support groups<br><br>Professional and peer support service included respite care for grandparents involved in SUD/SED/SMI-related caretaking<br><br>Legal rights of grandparents made known/supported | # of grandparents receiving caregiver support services | # of grandparents receiving caregiver support services<br><br>% of grandparents receiving services connected to peer support |
| **Children** | **Adverse Childhood Experiences (ACEs)** (trauma) constitute a major risk factor | Screening for childhood trauma; provision of trauma-informed treatment methods; | % of clients screened for ACEs | Community wide incidence of child abuse, neglect & other ACEs |

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| | for early SUD development and greater SUD severity (Taplin et al., 2014; Austin et al., 2017), including overdose (Lake et al., 2015), although these effects may differ by substance and ethnicity (Werner et al., 2016). | overdose prevention education; monitoring recurrence of behavioral/substance health issues in family | | # parental deaths of children under age 16<br><br># of divorces<br><br># in-county school transfers<br><br>Recovery capital score of family/child (e.g. family intact, stabilized in treatment, quality of home life, job, medical care, service, school, etc.) |
| **Children** | **Recovery Support & Family Reunification** Comprehensive cross sector programs for substance affected women and their children produce increased family reunification rates but often require support beyond time-limited reunification expectations (Brook et al, 2007). | Provision of recovery and parenting coach to women recovering from an SUD within the child welfare system | % of CWS involved parents in treatment<br><br>% of CWS-involved parents treated for SUD who receive recovery coaching. | % of funded SUD treatment programs that have a family/child treatment track<br><br>Rates of Substance-related family reunification & permanency outcomes |
| | Medication assisted treatment (MAT) of opioid | Expand access to MAT and recovery coaching for parents | # of CWS-involved parents receiving | # of CWS-involved parents receiving MAT |

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| | addiction (Hall et al, 2016) and recovery coaching (Ryan et al., 2016) have independently been found to enhance maternal SUD recovery rates and rates of parent-child reunification. | in the child welfare system (CWS). | MAT | % of MAT parents connected to specialized recovery groups |
| **Adolescents** | **Protective factors** that lower the risk of AOD problem development among youth include: 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) (Theokas et al., 2005). Family specific protective factors include a positive relationship with the non-addicted parent, close supervision by the non- | Service goals could include: attachment of each child with at least one caring adult, availability of at least one positive, encouraging role model for each child, balance of emotional closeness and support with clear behavioral expectations, ensuring regular parent-child time, consistent family rituals, positive ethnic/cultural identification, availability of teaching/coaching life skills and competencies, clear expectations/consistent discipline (including AOD use rules), communication of high expectations, encouraging dreams and aspirations via | Changes in recovery capital during treatment and follow-up<br><br>Implement a transmissible liability index (TLI), e.g. DUSI-R, if available, to predict vulnerability. | Develop asset markers for inclusion in consumer survey of CATAYF<br><br>Use survey data to plan recovery community asset development activities and track aggregate measures of community recovery capital |

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| | addicted parent, quality relationships with both parents, maintenance of key family rituals, e.g., family celebrations (birthdays, holidays), family traditions (vacations, reunions), and patterned routines (meals, bedtimes), and access to social support outside the family (Studies reviewed in White, Evans et al., 2009) | identification of strengths and interests, and attachment to extended family and social network (Kumpfer et al., 2004). | | |
| **Adolescents** | **Early Age of Onset (EO)** of first drug use, age of first intoxication (FI), and shorty delay between EO and FI exert a profound influence on the later trajectory of AOD problems (Sartor et al., 2016; Morean et al., 2014; Caetano et al., 2014) though this risk may be substance specific (Ohannessian et al., 2015). EO gender gap has disappeared to point that by mid-adolescence, females are more likely to initiate drinking than males (Cheng et al, 2016) | Parenting education on EO effects and importance of preventing/delaying onset of drug exposure via parental communications and supervision; "oversight and supervision of adolescents are critically important as is inculcation of consequential thinking" (Tarter, 2019) Concentrating youth prevention resources on the middle school years | Average age of onset of drug use among treatment admissions | Local AOD use survey data (youth binge drinking rate & other drug use rates) compared to national data (e.g., Monitoring the Future)<br><br>Annual average age of onset of drug use at treatment admission Average age of onset of drug use in community<br><br># of professional education events including recovery definition and recovery |

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| | and experience a more rapid transition to alcohol dependence (Cheng, Chandra et al., 2016). EO has been associated with greater SUD risk, faster problem progression, & greater problem complexity / chronicity (White, Evans et al., 2009). Risk of EO of drug use is amplified by early age of SED onset (Birrell et al., 2015) | | | capital measurement, including CATAYF definitions and measures |
| | Energy drink consumption has been linked to early drinking onset (Mann et al, 2016) and subsequent drinking-related problems (Arria et al., 2016), as has tobacco smoking & poly-tobacco use (Conway et al., 2018) | Add energy drink use to data collected at assessment; use risk cluster to target early adolescents in need of sustained monitoring and support | Test EO of energy drink use as a predictor of SUD severity, complexity, & chronicity | |
| | | Assess all substance use, e.g. marijuana, vaping, juuling, topical ointments, caffeine, etc. | Assess and address all substance use during treatment, in post-treatment recovery checkups & reporting of program outcomes | # of community education programs on new or other substance use that may be harmful to community |

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| | **Adverse childhood experiences (ACEs)** (addicted or mentally ill parent, parental discord/separation/divorce, or physical/sexual abuse) increase the likelihood of early onset of drinking and subsequent SUD risks (Rothman et al., 2008) | Targeting youth with ACEs for focused prevention and early intervention services | Measure presence of trauma& traumagenic factors (EO of trauma, trauma duration, multiple perpetrators, boundary invasive forms of trauma, inadequate family or institutional response to trauma, etc.) | Community level ACE measures<br><br>Average recovery capital scores of adolescents admitted and discharged from treatment |
| **Adolescents** | **Peer/Family Influences on SUD** Middle-school youth with behavioral health problems are at increased risk of substance use and related problems during high school entry (Burdzovic Andreas et al., 2015).<br>Peer group socialization exerts a significant influence on adolescent substance use (Beardslee et al., 2018; Martins et al., 2017; Ennett et al., 2006). This risk includes non-medical use of prescription medications | Primary prevention programs in all middle schools<br><br>Middle school student assistance programs and counsel availability<br><br>Therapeutic resources linked to juvenile court / detention / probation | Measure perception of peer AOD use<br><br>Provide normative information on peer AOD use | Annual survey data on middle school AOD use<br><br>% of youth reporting AOD using opportunities<br>Changes in community recovery capital scores that support adolescent health and recovery |

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| | (Boyd et al., 2016), with risk of non-medical prescription opioid use presently higher among non-Hispanic white adolescents in rural communities (Monnat et al., 2016; Vaughn et al., 2016)<br>Family rejection, school victimization, and discrimination increases SUD-development risk of LGBTQ youth and young adults (Johns et al., 2018; Hatchel et al., 3018; Klein et al., 2016; Huebner et al., 2015; Slater et al., 2017). | LGBTQ-inclusive professional & public education | LGBTQ-specific recovery support information dissemination | |
| **Adolescents** | **Other SUD Vulnerability**<br>Youth in foster care, independent living and those diagnosed with PTSD or conduct disorder are at increased risk for SUDs (Braciszewski et al., 2012; McMillen et al., 2007).<br><br>Co-Morbidity Risk Youth successfully treated for depression have decreased | Focused prevention and early intervention resources for youth involved in child welfare system and in mental health service system<br><br>Screen each adolescent for all medication and substance use<br><br>Review prescribed medications regularly for clinical effectiveness and safety | # of at-risk youth engaged in services<br><br>% of youth admitted to SUD Tx with co-occurring SED/SMI | # of at-risk youth engaged in services<br><br>% of youth with co-occurring disorders who receive integrated care |

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| | risk of future SUD but remain at risk for alcohol-related problems (Curry et al., 2012) | | | % receiving targeted peer support |
| | **Family Influences** Family factors influence SUD vulnerability and recovery outcomes, particularly for minority youth (Wang et al., 2005) | Monitoring adolescents treated for SED/SMI for future SUD/AUD risks<br>Family inclusion and family-focused treatment of adolescent SUDs | #/% of adolescents treated for SUD whose families were involved in Tx<br><br># of family-inclusive sessions | # of family inclusive sessions with SUD youth within funded agencies |
| **Adolescents** | **Evidence-based Treatment** (EBT) There are evidence-based, brief individual/group therapies for substance-involved adolescents, e.g., MI, CBT, MDFT, ACRA, TSF, etc. (NIDA, 2018)<br>Twelve-Step Facilitation with adolescents produces comparable recovery outcomes to motivational enhancement therapy/cognitive-behavioral therapy (Kelly, Kaminer et al., 2017)<br><br>Adolescents may need special | Training of local SUD service providers & clinical supervisors in adolescent EBTs<br><br>Linking funding to EBT provision<br><br>Training supervisors in EBT fidelity monitoring<br><br>Introduce adolescent to various pathways to recovery | EBT fidelity monitoring ratings<br><br>Clinical supervision documentation<br><br>Connect treatment to chosen supportive pathway to recovery | Quarterly # of EBT training sessions provided<br><br>% of funded adolescent treatment programs using EBTs<br><br>% in treatment connected to recovery pathway or support |

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| | supports to enhance recovery mutual aid (RMA) participation due to logistical obstacles, lower motivation for recovery, and problems with identification with older mutual aid members (Labbe et al., 2014) | Youth-focused recovery coaching during and following primary treatment<br><br>Encourage development of local Young People in Recovery chapter | % of youth successfully linked to RMA groups | # of young people's RMA meetings in community<br><br>Completion rate of adolescents across levels of care |
| | Duration and completion of initial inpatient treatment and subsequent duration of medication support is associated with improved abstinence outcomes for adolescents in medication assisted treatment of opioid use disorders (Mutlu et al., 2016; Smyth et al., 2018; Chang et al., 2018) | Use of recovery coaching to enhance treatment retention and level of care transitions | Completion rate of adolescents across levels of care | % of adolescents in treatment self-reporting as "in recovery." |
| **Adolescents** | **Treatment Outcome**<br>Recovery/remission rates for adolescents following specialty SUD treatment average more than 40% with remission spanning | Integrate post-treatment recovery checkups and treatment evaluation data collection | Report all outcomes across categories of abstinence, asymptomatic use, symptomatic use, & persistent/recurrent | One-year post-treatment SUD remission rates<br><br>Remission/Recovery % at 90 days, 6 months and 1 year |

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| | continuous abstinence and asymptomatic use—patterns that vary by problem severity (White, 2012) | | SUD | |
| **Adolescents** | **Post-treatment Fragility** Most adolescents are precariously balanced between recovery and resumption of AOD use following addiction treatment, particularly during the first 30 days following treatment; AOD status at 90 days following treatment is highly predictive of recovery status at one year following treatment (Godley et al., 1999).<br><br>Recovery stability is enhanced by assertive continuing care, e.g. post-treatment monitoring & support via recovery checkups (Godley et al., 2007) & can be cost-effectively delivered using lay volunteers (Godley et al., in press). | Assertive approaches to continuing care (ACC)<br>--all admitted clients/families, not just "graduates"<br>--primary responsibility for continued contact rests with the treatment institution<br>--capitalizes on temporal windows of vulnerability (saturation of monitoring and support in the first 90 days following treatment)<br>--individualizes the duration and intensity of monitoring<br>--utilizes assertive rather than passive (verbal encouragement only) linkage to communities of recovery<br>--incorporates multiple media for sustained recovery support<br>--emphasizes continuity of contact in a primary recovery support relationship over time (White & Kurtz, 2006). | % of clients receiving ACC for at least one year after primary treatment | % of adolescents readmitted to SUD treatment within one year |

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| **Adolescents** | **Peer Influences on Recovery** 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 posttreatment social milieu (Godley et al., 2005; Fisher, 2014; Best et al., 2016) | Monitoring & support with post-treatment social network reconstruction<br><br>Development of sober social activities for youth in recovery | Changes in social recovery capital during and first year following treatment | Average post-treatment recovery capital scores |
| | Adolescents involved in peer helping experience elevated recovery outcomes and quality of life in recovery (Lee et al., 2016) | Create peer helping and community service opportunities for youth in recovery | Integration of peer helping within treatment milieu<br># youth volunteers | # of youth in recovery serving as volunteers across funded agencies |
| **Adolescents** | **SUD Recurrence & Recovery Rates** Post-treatment SUD recurrence rates for adolescents are high and can result in recycling of adolescents through very expensive levels of care without measurable long-term recovery outcomes (Risberg et al., 2003) | Extend acute care models of intervention to models of sustained recovery management<br>Assertive models of continuing care | Post-treatment status of treated adolescents<br><br>% of treated youth readmitted within one year | # of adolescent self-reporting recovery within community health survey<br>% of treated youth readmitted within one year |

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| **Adolescents** | **Value of Recovery Mutual Aid (RMA)** Recovery mutual aid networks (AA, NA, SMART, Alateen, etc.) 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 (Kelly et al., 2008; Kelly & Urbanoski, 2012; Passetti et al., 2012). The value of recovery mutual aid participation extends to youth with co-occurring disorders, including those with a social anxiety disorder (Tonigan et al., 2018; Pagano et al., 2015) Studies of 12-Step participation among SUD adolescents note minimal concerns related to safety issues or other harm from such participation (Kelly et al., 2011) | Encourage development of young people's recovery support meetings and youth-focused recovery advocacy organization (e.g., Young People in Recovery)<br><br>Encourage utilization of youth-focused E-Recovery Support Resources<br><br>Monitor any safety issues that arise from youth RMA participation | #/% of youth successfully linked to RMA groups or a peer support network<br><br>One year youth RMA retention rate<br><br># reported negative effects from RMA participation | # of youth RMA groups meetings or % of peer connections<br><br># hits/links on Youth E-recovery resources on website |
| **Transition Age Youth** | **TAY Focus** TAY are a special population with distinct | TAY-specific service planning and evaluation activities | Documentation of TAY representation in | Documentation of TAY representation in service |

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| **(TAY)** | SUD/SED/SMI recovery support needs Settersten et al., 2005; Davis et al., 2009) | Targeted SUD prevention, HR, EI, TX, and recovery support services | service planning<br><br>TAY service utilization data | planning<br><br>TAY service utilization data |
| | **Transition Risk Factors**<br>Personal/family life transitions increase SUD risk and can weaken recovery stability, e.g., changes in residence, employment, family conflict/violence, marital status, health status, community reentry from military service or prison, exposure to community violence, etc. (Satre et al., 2012; Fleming et al., 2010; Meisel et al., 2017). | SUD screening/education within all mental health services includes training in trauma-informed care | | # of MH/Trauma trainings to population<br><br># of youth in child service system aged 17-18 |
| | TAY experiencing SED/SMI are at increased risk of subsequently developing SUDs (Miranda et al., 2016)<br><br>Child maltreatment and its residual effects constitute a recovery obstacles for TAY with SUD/SED/SMI (Yo et al., | Assure transitional supports for youth aged 18-21 who are aging out of the child service system. | | % connected to treatment or peer support |

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| | 2007)<br><br>Youth who have received institutional support for behavioral health problems may be at increased risk as they age out of these service systems (Heflinger et al., 2008; Ringeisen et al, 2015; Davis et al., 2006; McMillen et al., 2005) | | Measure of individual recovery capital obtained | Measure of individual recovery capital provided to person |
| **Transition Age Youth (TAY)** | **Vulnerability for SUD/SED/SMI onset and recurrence** increases for TAY due to relationship, residential, and financial instability (Elswick et al., 2018) | Targeted service marketing to TAY | # of TAY served | # of TAY served |
| | The transition to adulthood is a vulnerable period for health problems among African Americans as indicate by increasing rates of substance use and obesity (Chen et al., 2018). | Developing transition resources guides for TAY | #/% of African American TAY served | #/% of African American TAY served in comparison to population representation |
| | Young LGBTQ adults are at | Availability of flyer on LGBTQ recovery support resources | LGBTQ TAY served | % LGBTQ TAY served connected to peer support |

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| | increased risk for development of SUDs and may experience special obstacles to help seeking (Schuler et al., 2018; Demant et al., 2017.)<br><br>Internet-based services may be an effective medium to reach LGBTQ and other marginalized youth populations (Schwinn et al., 2015) | that includes E-recovery support resources | | |
| **Transition Age Youth (TAY)** | **Early Predictors of TAU AOD Problems** AOD problems at age 21 are associated with poor family functioning during adolescence (Lee et al., 2014) | Enhance adolescent/family support resources | | % of TAY seeking services whose families did not seek services during TAY's adolescence |
| **Transition Age Youth (TAY)** | **Limited Help-seeking among TAU** TAU access psychiatric and social services at lower rates than either adolescents or older adults (Copeland et al., 2015; Pottick et al., 2008) | Targeted marketing to TAY | | # of TAY served within funded agencies |
| **Transition Age Youth (TAY)** | **Mortality Risks** Polysubstance using TAY with co-occurring psychiatric disorders are at particular high risk of | OD education; Access to MAT | # Drug-related deaths among TAY | # Drug-related deaths among TAY |

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| | overdose death (Yule et al., 2018); overdose risks decline with entry into medication assisted treatment (Schiavon et al., 2018) | | | |
| **Transition Age Youth (TAY)** | **Harm Reduction (HR) Needs** Multiple factors underscore the need for a continuum of HR services for TAY, e.g., propensity for polysubstance use, risk-taking, substance-related mortality risks (Marshall et al., 2016) | HR to recovery service continuum | | # TAY receiving HR education and services |
| **Transition Age Youth (TAY)** | **Continuity of Care** Admission to treatment within 14 days of discharge from detox reduces treatment readmissions (Lee et al., 2014) | Use of outreach workers or recovery coaches in detox to encourage transition to other levels of care | % of persons discharged from detox services admitted to treatment within 14 days | % of TAY youth connected to continuing care and/or peer support prior to discharge from hospital<br><br>% of persons discharged from detox with "warm handoff" to treatment; peer support<br><br>% of persons discharged from detox services admitted to treatment within 14 days |
| **Transition** | **Treatment & Treatment** | Working with TAY across | Report all outcomes | TAY one year post- |

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| **Age Youth (TAY)** | **Outcomes** Post-treatment low-risk, asymptomatic drinking is achievable for some TAY with lower severity of alcohol use disorders (Witkiewitz et al., 2018; McCabe et al., 2018) | problem severity and patient-choices of treatment goals | across categories of abstinence, asymptomatic use, symptomatic use, & persistent/recurrent SUD; compile outcome as individual Recovery capital score | treatment outcomes; reporting of multiple outcome categories<br><br>%/status of post-treatment/ recovery follow-up completed at 90 days, 6 months and 1 year |
| **Transition Age Youth (TAY)** | **Recovery Mutual Aid (RMA)** Studies on effects of 12-Step participation among TAY report positive outcomes with sustained participation but some membership attrition over time as with other age groups (Hoeppner et al, 2014; Kelly Stout et al 2013). RMA participation is linked to density of TAY populations within RMA groups (Labbe et al., 2013 & 2014; Kelly, Stout, 2014) | Assertive linkage to groups with TAY membership<br><br>Identify MRA dropouts within recovery checkups with re-linkage to alternative groups | #/% of TAY successfully linked to RMA groups | #/% of TAY successfully linked to RMA groups |
| | | Use professionally-led continuing care groups as alternative TAY support in areas lacking TAY MRA involvement | # of TAY participating in continuing care groups | # of TAY participating in continuing care groups |
| | Both post-treatment RMA participation and professional continuing care elevate TAY recovery outcomes (Bergman | Encourage development of specialty RMA groups, e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery | | # of RMA meetings per month for people with co-occurring SUD/SED/SMI |

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| | et al., 2015)<br><br>TAY with co-occurring disorders may benefit from RMA groups specifically for people who share these multiple challenges (Hagler et al., 2015) | | | |
| **Families** | **Role of Family in Recovery Initiation** There are evidence-based models of family training and support that increase help-seeking of an addicted family member (Meyers et al., 1998; Miller et al., 1999; Foote et al., 2014). | Provide family skill building as a support service to SUD-affected family members | # of family members calls for assistance also successfully linked to CRAFT | # families participating in CRAFT or skill building and support |
| **Families** | **Scope of Family SUD Recovery** spans 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, | Shift from person-focused care to family-focused education, intervention and care within ROSC initiatives; unit of service becomes the "family" as defined by the primary patient | Development of family health indicators<br><br># of CRAFT or other family trainings given | Family representation in systems decision-making<br><br># family members serving as volunteers or advocates<br><br># of family support groups offered<br><br>Development of family recovery capital instrument |

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| | enhanced quality and flexibility of external boundary transactions (the family's relationship with outside kinship and social networks), & reduction of risk for intergenerational transmission of SUDs and related problems (White & Savage, 2005) | Training in trauma informed care provided to families and/or caretakers | | % of families receiving trauma based care training |
| **Families** | **Parenting Effects on Child SUD Risks** Child exposure to parental drinking is linked to earlier onset of drinking and greater association with deviant peers which in turn is linked to increased drinking in young adulthood (Mahedy et al., 2018). "A child's psychological propensities toward SUD are enhanced by parental modeling, including frequent intoxication, use of illegal drugs, taking addictive medicines without physician oversight, AOD use as a response to emotional distress, DUI, and | Parent education on effects of parental drinking exposure on CATAY development<br><br>Community education on family interventions is made available, e.g. CRAFT training (Foote et al., 2014).<br><br>Parenting in Recovery training as an adjunct to clinical services | Parenting education integrated into community education and addiction treatment<br><br># of parents linked to parenting training<br><br>% of parents reporting one or more of following: family check in on return from school or work, regular family | Age on onset of alcohol use within community surveys<br><br># of community education programs on family interventions and recovery supports<br><br>% of young people admitted to SUD treatment reporting parental SU problems<br><br>% of cases where "the family" is designed as the unit of care as addressed collectively |

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| | incarceration."(Tarter, 2019) Weak monitoring has been linked to increased involvement with AOD-using peers, and strict alcohol-specific rule setting and monitoring in combination with warm parent-child communication have been shown to lower rates of early alcohol exposure and alcohol-related problems (Konig et al., 2014; Li et al., 2014).<br><br>Disrupted family rituals play a significant role in the intergenerational transmission of AOD problems (Wolin et al., 1980).<br><br>"Consolidating heath behaviors such as regular eating and sleeping schedules, physical exercise, hygiene, and safety measures (, e.g., wearing a helmet or seat belt) reinforces self-efficacy and | Necessary releases for family and multi-agency communication signed<br>System support and guidance for family intervention is made available<br><br>Family ritual planning within parenting in recovery education<br><br>Culture development and linkage to indigenous cultural resources for recovery support | meals, family holiday rituals, family vacations, etc. | % of families connected to Family Coaching or Peer Support (e.g. Al-Anon, Alateen, Family Support Groups)<br><br>% of families reporting establishment or resumption of family rituals following treatment |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
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| | emotional well-being" (Tarter, 2019). | Include value and teaching of science and recovery based health-related behaviors within parenting in recovery curriculum | | |
| **Families** | **Family Treatment Drug Courts** are a promising intervention for SUD parents involved in the child welfare system, with studies showing enhanced rates of recovery and family reunification (Zhang et al., 2018) | Collaboration with Family & Drug Courts or procedures to assure family inclusion in drug/recovery court programs<br><br>Connection of families to existing court or community treatment | # families involved in court intervention program | # of families or family services linked to SUD/MH court or community treatment/services programs<br><br>% of families and % of individuals connected to peer support<br><br>% of families remaining intact during and following service provision |
| **Families** | **Family Life in Recovery** Survey data is available documenting the long term positive effects of recovery on the family in such areas as physical health, relational health, housing stability, financial security, etc. | Conduct family health assessments for all persons admitted for SUD/SED/SMI treatment | | Pre-Post treatment measures of family recovery capital & health<br><br>% of admissions in which family recovery capital was used in treatment planning |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
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| | (Andersson et al., 2018) | | | % of families treated as a unit and held intact |
| **Families** | **Recovery & Family Distress** Parental recovery initiation, by suddenly destabilizing addiction-shaped family roles, rules, rituals, and relationships, can exert strain on family members and the family system as a whole during the early stage of recovery. Such strain, without sources of support, can destabilize the adult intimate relationship, lead to emotional/behavioral problems in children, and threaten family stability (Brown & Lewis, 1999) | Professionally facilitated family programs that educate and support families in early recovery.<br><br>Assertive linkage to peer-led family and couples recovery support groups | Review of family stability status and health within recovery checkups | Changes in marital status within life in recovery surveys<br><br>Assess effects of life disruption on sustaining recovery |
| **Families** | **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 (Powers et al., 2008). | Family/couples therapy and family support services<br><br>Treating "family" as a unit in care | Changes in marital and living circumstances during and following treatment<br><br># of parents completing parenting | Changes in marital and living circumstances during and following treatment<br><br>Increased recovery/peer support during life changes<br><br># of parents completing parenting training |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
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| | **Maternal Effects of Parenting Training** Parenting training integrated into SUD treatment enhances maternal recovery outcomes (Moreland et al., 2018)<br><br>Gender specific culturally informed treatment can enhance recovery outcomes for pregnant and post-partum women (Krans et al., 2018 McCarron et al., 2018) | Parenting training as adjunct to clinical services<br><br>Gender-specific treatment settings and services<br><br>Early specialized prenatal care for dependent pregnant women<br><br>Specialized new born care in hospitals and continuing care | training<br>Service retention / completion rates by gender identification<br><br># of pregnant women in specialized care<br><br># of babies born to women in specialized program | Service retention / completion rates by gender identification<br><br># of pregnant SUD women in specialized program<br><br>% of newborns born without significant morbidity or mortality. |
| **Families** | **Parenting/Sibling Influence on Child AOD Use** Parenting interventions that prevent, delay, or reduce child AOD use include cautionary communications about drinking, drinking rules, drinking consequences, and reduced exposure of children to parental drinking and access to alcohol and other drugs within the home(Cox et al., 2018; Maggs et al., 2019). | Include AOD-specific parenting messages and prevention knowledge within parenting in recovery training<br><br>Inform and empower parents to find help for child AOD use | % of parents reporting AOD problems of one or more of their children<br>% of parents who have provided one or more of the noted AOD interventions in past month | # of parenting in recovery meetings<br><br># of parents in SUD treatment completing parenting training<br><br>Parent feedback surveys to strengthen system# of education and prevention sessions with community, family and individual |

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| | Horizontal SUD Transmission: Younger siblings of older youth with AOD problems are at increased risk of developing such problems (Luthar et al., 1992; Windle, 2000; Tarter, 2019). | Target the younger siblings of adolescents and young adults admitted for addiction treatment for prevention and early intervention services | # of siblings involved in education/support activities | |
| **Families** | **Peer Support** There are emerging models of peer delivered, family-to-family (F2F) SUD recovery support (Anthony et al., 2018) and peer support groups (e.g., Grief After Substance Passing, GRASP) for families who have experience a substance-related death in the family. | Family led recovery support groups in each community<br><br>Input from families incorporated into development of system of care | # of family members participating in parent recovery support groups in past month | # of family support group meetings per month<br><br>All pathways to recovery, faith based and other, are recognized in support groups |
| **Families** | **Family Recovery Cost Benefits** Addiction treatment and recovery stabilization produce future lowering of medical costs for family members (Weisner et al., 2010). | Screening physical health of other family members during SUD/SED/SMI admissions<br><br>Linking other family members to primary care resources as needed | # family primary care referrals in past month | # family primary care referrals in past month<br><br>Changes in ER use, hospital admissions, arrests, OD, incarceration, , etc. over time<br><br>Improved aggregate Family Recovery scores in |

| Population | Research Finding | Potential Service Interventions | Potential Program/Clinical Measures | Potential Systems Measures |
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| | | | | community |

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# Collegiate Recovery Programs to Recovery Studies

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A lot is happening in the world of addiction recovery. The growth and international dispersion of secular, spiritual, and religious recovery mutual aid organizations. The exponential growth of online recovery support resources. The emergence of resistance, resilience, and recovery as alternative organizing concepts for policy, planning, and funding bodies. Increased representation of people in recovery within addiction-focused policy and planning venues. Efforts to shift the design of addiction treatment from models of acute care to models of sustained recovery management nested within larger recovery-oriented systems of care. Expansion of peer recovery support services as adjuncts or alternatives to professional treatment. New recovery support institutions: recovery community organizations, recovery community centers, recovery residences, recovery support within educational settings, recovery industries, recovery ministries, recovery cafes, recovery music festivals, recovery adventure and sports venues. Large public recovery celebration events. Recovery-focused political lobbying. Expanded funding for recovery-focused research studies and an increase in the number of research scientists specializing in recovery research.

These and related innovations are the downstream effects of the cultural and political mobilization of people in recovery and their allies. The emergence of a new recovery advocacy movement and an ecumenical culture of recovery reflects an important historical shift: people from diverse pathways of recovery identifying themselves as “a people” with a distinct history, shared needs, and a linked destiny. As this movement transitions beyond mass mobilization and institution building, it is pushing recovery-friendly policies and practices within law, government, health care, popular and social media, religion, business and industry, entertainment, and education.

Recovery-focused activities are evident in two arenas within institutions of higher education: the growth in collegiate recovery programs and recent calls for the creation of “recovery studies” on par with earlier academic specialties, e.g., Black/minority studies, women’s studies, disability studies, and queer studies.

## Collegiate Recovery Programs

Collegiate Recovery Programs (CRPs) are structured supports for students in recovery on college campuses. The Collegiate Recovery Movement began at Brown University in 1977 and was later joined by programs at Rutgers, Texas Tech, and Augsburg. However, by the 2009 founding of the Association of Recovery in Higher Education (ARHE), there were still only a handful of such programs nationally. That has

changed dramatically over the past 10 years as there are now more than 150 schools hosting a collegiate recovery program, spurred in part by a large grant program through Transforming Youth Recovery. These programs have evolved and diversified their scope of services: from the original schools whose programs were more formally structured and 12-Step focused, to programs that offer and support many pathways to recovery and provide a range of intensity and formalization of services.

While addiction-related stigma remains a problem among many University administrators and faculty, some schools have embraced CRPs as a part of larger equity and inclusion efforts. Students in recovery on campuses often report feeling marginalized and threatened by what are usually "abstinence-hostile environments". The creation of recovery spaces, especially physical spaces with dedicated staff, offers students a retreat within the campus environment and serves to validate and support their identities as people in recovery. CRP Students are, on average, significantly older than other college students and thus are often managing additional challenges from being the oldest student in the class, to child care, part or full-time work, heavier familial responsibilities, and other obligations within their recovery community. CRPs seek to not only validate these students but to elevate and celebrate them as they balance school, work, and management of a chronic, and potentially fatal health condition.

**Towards Recovery Competence as Cultural Competence**

Efforts to grow recovery supports on college campuses are only a part of addressing a University's responsibility towards people with severe substance use disorders and those in recovery. Far more people in recovery have and continue to navigate the rigors of higher education without CRPs. These students, like many staff and professors on college campuses, separate out their recovery identity from the relationship with the institution. This can create uncomfortable identity conflicts and also robs these institutions of the experience and wisdom that people in recovery have to offer. Creating spaces that encourage and nurture recovery identity enriches the experience of students, faculty, and staff across the university. It is also a moral and ethical imperative for schools that receive tens of millions of dollars in substance-related grant funding to provide recovery support for their own students, staff, and faculty.

Anecdotally speaking, people in recovery are well represented as students and professionals in fields such as substance use counseling, social work, psychology, rehabilitation, and mental health counseling. This is unsurprising given the academic trope "research is me-search". In many of these classes and professions, students report their experiences being poorly represented or missing entirely in the literature, and worse are often discouraged explicitly or implicitly from sharing their recovery status in their programs or professions. Researchers in recovery frequently hide their recovery status to avoid being labeled as biased or for fear of reprisal within the tenure process. The irony and hypocrisy of the extensive stigma within both the academy and the field perpetuated by many in these "helping professions" demonstrate the necessity for

explicit study and celebration of people in recovery through curricular inclusion and expectations of continual development of cultural competence around recovery for professionals.

Universities must learn from the tremendous contributions of Black Studies, Women's Studies, LGBTQ and Disabilities studies departments who have not only greatly enhanced their own University's dialogues around these issues but have provided the intellectual bedrock and framework of the most important movements towards equity and justice in our country. These programs have infused subject matter expertise and the voices of people within the communities into the content of teachings throughout the University, while also creating stand-alone fields. In the same way, the serious academic study and teaching of recovery on campuses across the country has the potential to greatly enhance the fields of Psychology, Social Work, Medicine, Counseling, Pharmacy, and Nursing and, in so doing, create a generation of professionals who have cultural competence in recovery, while also highlighting and celebrating recovery voices.

**International Programme of Addiction Studies (IPAS)**

The International Programme on Addiction Studies (IPAS) is a unique and distinguished academic study program that offers a global understanding of critical issues in the field of addiction. Primarily focused on prevention, treatment, policy, and research, IPAS brings together three of the world's leading research universities, King's College, London, the University of Adelaide, and Virginia Commonwealth University. Through distance learning, the Programme offers three graduate options to its students: a Master of Science in Addiction Studies, an Intermediate Graduate Certificate in International Addiction Studies, and an Advanced Graduate Certificate in International Addiction Studies.

Students learn to think critically about issues within the field of addiction science. Although recovery is not the primary focus of the program, students are taught to apply their critical knowledge of the field of addiction science to a variety of settings, including community-based settings addressing recovery supports and services, i.e., peer recovery support services, recovery community organizations, recovery community centers, recovery residences, and education-based recovery support services. The research project required to earn the Master of Science degree addresses key questions in addiction science and assists students in appraising the research literature and translating it into more effective policies and practices.

For many students, this course of study becomes part of the process to earn a PhD. For others it offers a more in depth opportunity to explore and analyze some of the discrepancies, gaps, and issues that exist in the addictions field. Individuals in long-term recovery have graduated from the program, most of whom are seeking to use their passion, lived experience, and knowledge of addiction science to prepare them for work

in a variety of settings. One recent graduate has used the skills and knowledge received in the Programme to lead national recovery efforts on behalf of individuals and families in recovery.

More research is needed to advance the field of addiction, and to advance the understanding and field of addiction recovery. As more individuals develop an interest in addiction recovery, research programs like the International Programme on Addiction Studies will emphasize recovery as one of the focus areas of their programs. Until then, it is one of the only programs that requires exceptional students to extend their learning and focus their research projects on facets of recovery. These men and women are among the pioneers of the growing numbers of addiction recovery researchers and practitioners who are paving the way for the next generation and making huge strides in the understanding of and outcomes associated with addiction recovery in all of its phases, stages, and other expressions. Additionally, the multi-country, multi-site, and online nature of the collaboration creates opportunities to study and understand recovery in a variety of cultural contexts and pathways to recovery.

**Recovery Studies**

The addiction recovery field has undergone incredible growth over the past several decades. Even though many within the field have embraced a shift from pathology and clinical intervention to a focus on long-term personal and family recovery, many professionals still view and treat addiction as an acute condition.

With the lack of knowledge and expertise about recovery, there is a great need for qualified and trained addiction recovery professionals, including clinicians and researchers within the field. The need for these professionals will only increase over time as more and more people meet the criteria for severe substance use disorder and enter into recovery. Educational programs for mental health providers (e.g., social workers, counselors, marriage and family therapists, etc.) often do not have any classes dedicated to addiction let alone a focus on recovery. In addition to this lack of training, very few doctoral programs train researchers to study addiction and recovery. Thus, although more than 20 million people are in recovery in the United States, we do not know enough about how people enter recovery, navigate recovery, the multiple pathways of recovery (and what works for who), and how individuals and families stay in recovery over a life-time. The recent National Recovery Study indicated that on average it takes more than a decade of recovery for an individual to experience happiness and self-esteem on par with the rest of the population. We know too little about how to enhance the quality and durability of recovery.

Many bright and capable people have written and studied recovery in the past and their work provides a platform that is ripe for clinical improvement and scientific inquiry. Potential elements of recovery studies could include the following: history of

addiction recovery, defining and measuring recovery, prevalence of recovery, neuroscience of recovery, multiple pathways of recovery (including harm reduction), stages of recovery, recovery durability (together with recurrence rates and risks), bio-psycho-social nature of addiction and recovery, behavioral addiction and recovery, and family and community recovery (within systems theory). In addition to these, we as professionals in the field need to understand the role and effectiveness of professional treatment and the power of recovery mutual aid organizations including extending recovery support through peer and community-based solutions (e.g., Collegiate Recovery Programs, Community Recovery Centers, etc.). Recovery studies should also include the relationship of recovery to prevention, early intervention, and the current issues and trends of the addiction recovery field.

For those who wish to be good consumers of recovery research or conduct that research, an understanding of the relevant literature and theories of recovery is necessary. Also, students of recovery must delve deeply into advanced research methods, both quantitative and qualitative, including advanced statistics. It is beyond time for the addiction recovery field to elevate ourselves to academic excellence and scientific rigor.

Texas Tech University's (TTU) Department of Community, Family, and Addiction Sciences (CFAS) offers some insight into how educational programs can integrate recovery studies into their curriculum. In 1986, Texas Tech started a minor in Substance Abuse Studies (SAS), which attracted many students in recovery. These SAS students in recovery were taking classes to meet the educational requirements to become Licensed Chemical Dependency Counselors (LCDC) in the state of Texas. In 1988, Dr. Carl Anderson, a professor in the program and a person in long-term recovery himself, formed the Center for the Study of Addiction, which was one of the first collegiate recovery programs. The Center was later named the Center for the Study of Addiction and Recovery (CSAR 2003-2013) and is currently named the Center for Collegiate Recovery Communities (CCRC) (2013 – current). The name changes of the Center reflect the evolving understanding of addiction recovery and a transitional focus not only on recovery generally but on TTU's collegiate recovery program specifically.

The SAS minor served and educated numerous students over many years. As the demand for more addiction recovery classes grew in 2007, the Community, Family, and Addiction Sciences (CFAS) department was formed and an undergraduate major in community, family, and addiction recovery was approved and implemented. The CFAS Department also offered programs in human services, addiction and recovery, and couple, marriage, and family therapy—with integrated classes on addiction and recovery. During the formation of the CFAS undergraduate degree, the former SAS minor was updated and underwent a name change to Addiction Disorders and Recovery Studies (ADRS).

Currently, the ADRS minor offers courses in understanding addiction and recovery, family dynamics of addiction and recovery, prevention, relationships, treatment, and research in addiction recovery. The minor continues to meet the

educational requirements to become a LCDC in Texas. Presently the CFAS undergraduate major has 65 students and the ADRS minor has 302 students.

In July 2017, after many years of work, the CFAS department gained approval to start perhaps the first PhD. program focused solely on addiction recovery research. Grounded in Family Systems Theory, the ADRS PhD is a timely and unique program with the goal of creating scholars and academicians who have a passion for the science of addiction recovery. These doctoral scholars will have an understanding of addiction recovery, including relevant literature, recovery theories, and research methods and statistics. The students will be prepared to advance the field of addiction recovery with scientifically rigorous research studies from both the qualitative and quantitative traditions. The first cohort of PhD students started their work fall, 2019. Many within this first cohort of PhD students are persons in long-term recovery and products of collegiate recovery programs. With such a wonderful platform of recovery science built for us as a field, the future of addiction recovery knowledge, understanding, and research is bright.

## Closing Reflection

Multiple factors set the stage for the expansion of collegiate recovery programs and the development of recovery studies programs at undergraduate and graduate levels. The former provide a dual emphasis on recovery support and academic excellence; the latter signal the recognition of addiction recovery as an important subject for critical academic inquiry. Historically, experiential knowledge and professional/scientific knowledge exist as two separate worlds within the alcohol and other drug problems arena. Collegiate recovery support programs and recovery studies curricula offer a potential bridge of integration between these two worlds. The future of recovery may rest within that integration.

## Disaster Relief and People in Recovery

Michael Galipeau with Commentaries from Ryan Hampton and Bill White

My name is Michael Galipeau, and I'm a person in long-term recovery. I'm also a proud small business owner and taxpayer. In 2018, I paid more tax than many large corporations, including John Deere, which has claimed that the federal government owes $268 million in tax refunds from deductions and various other credits after reporting $2.15 billion in pre-tax income. This was all before COVID-19 happened. What has happened since is simply hard to believe, so I wanted to share my experience with my fellow Americans.

I remember worrying frantically as my scheduled concert was rapidly approaching. I had a performance scheduled on March 21st for a celebration of the spring equinox, which was a huge collaboration of some of my favorite artists and friends. I remember with a heavy heart having to make the decision to announce to our fans that we were no longer going to be holding our performance, and that our show would be postponed until further notice. I could hardly have anticipated at that time what this would mean for the rest of the season.

I worried for my friends and fellow artists, many for whom there is no alternative for work. Many of whom work on comps and cash payments, have no formal work history, and have informal contractor relationships with each other and within the community. Many of whom work second jobs, like myself, to be able to make ends meet. Between the extremely high rents in New York state, combined with the sudden competition for rent with folks fleeing the city, student loan debt, and daily living expenses, life is extremely hard for a 30-something trying to make it in today's economy. This was of course true long before COVID-19. As a graduate of an accredited school of social work with a full-time job, I have never known a life where I was not living paycheck to paycheck. Student loan debt and debt payments have long been a presence in my life, and having multiple incomes is a necessity, rather than a luxury. With incredibly low salaries and incentives in my field, many service professionals are forced to take on second jobs or open small businesses—small businesses that are not only our source of livelihood, but for many of us, critical to our survival. Then COVID-19 happened.

I remember feeling like I was holding my breath as my roommate moved out suddenly when she could no longer afford to pay rent. I remember the heartache I felt as I heard story after story from my friends who could no longer make ends meet, as online replacements for their work were often insufficient, or in some cases, like my friend who specializes in projection lighting, simply not replaceable. Hearing story after story of individuals in my community struggling, other people in recovery struggling with job loss and isolation, people moving to their cars to avoid eviction, and people simply falling off the face of the earth during the crisis. I can honestly say I don't know what has become of many of the people I worked with for years prior to this crisis. I hope they are okay.

My hopefulness and my practicality are at odds over this point—as I know from working in the recovery field that many of the folks in our community are experiencing addiction recurrence and dying.

So when I heard about the economic stimulus and the disaster loan program I felt a surge of hope. I diligently collected my paperwork, and submitted my information immediately, fearing shortages or program closure. I continued to check the IRS website for my economic stimulus, which unfortunately continued to tell me that they could not determine my eligibility with the information they had on file. I was told by the media that I could provide a bank account for the direct deposit to the IRS via the "check my status" link. For over a month I continued to check, and this option never came available. See, as a taxpayer, I would not have provided my banking information to the IRS in 2018 for a direct deposit. Feeling frustrated and powerless, I did what my recovery principles have always directed me to do, focus on what I can change, and let go of what I cannot.

So I turned to my disaster loan application. I placed an application for the Economic Impact Disaster Loan, or EIDL immediately, and was encouraged when I received the temporary assistance within weeks. Of course, as a sole proprietor with a second job and contract employees, I did not qualify for the paycheck protection program or unemployment. The EIDL would appear to be my last resort for financial support. First I filled out an application on the https://disasterloan.sba.gov/ website on March 22nd immediately following my cancelled show, as I had contracts and taxpayer records of income to support my claim for lost income and needed financial support. I was notified shortly afterwards that the server had crashed, and a new application needed to be submitted. This time I was directed to a new portal on the https://covid19relief1.sba.gov/ website. I completed a new application with a completely different set of information. I didn't think twice when the application asked me about my criminal history—I mean, who's really going to withhold critical financial support for a small business, particularly a vulnerable small business, during a national pandemic emergency with mandatory shutdowns. So I checked the box, completed the rest of my application and clicked submit.

It wasn't until a month had gone by that I received a curious email from the Small Business Association, or SBA to set up an account. I thought this was a bit strange, as I had set one up a month prior when I submitted my application. I clicked the link, which of course turned back an error, notifying me that I did indeed already have an account, and that this email must have been the result of some kind of server error. So I figured I would check on my account since I had already come this far. When I logged in I discovered my loan had been selected, and was being processed. I needed to perform an electronic signature after selecting an award amount, which given the now extended nature of the crisis, I predicted to be adequately supportive at a mere $18,500—the amount of my documented supplemental income that was lost for this year. I submitted

these documents, and awaited a call from a loan officer.

The Friday that I received the call from the loan officer is one I will probably remember the rest of my life. The conversation wasn't very long, it didn't need to be. The loan officer had called me to inquire about the box I had checked about my criminal record. When he asked me if this was true, of course I said yes. He asked about the nature of the charges, which I told him because they were drug charges, they were felonies. He then explained to me that he would be denying my loan, as a matter of public policy, anyone who has ever been arrested for a felony is not eligible for a disaster relief loan for the rest of their life. The shock I felt left me numb, grasping for any sense of reality that I could reach for.

I explained to the gentleman that I was a person in long-term recovery and what that meant. That my business provided services, training, and support for people who were serving on the front lines of the opioid crisis. That as a small business, I had trained police, fire, EMS, medical professionals, taught in schools, developed and provided fentanyl testing kits for municipalities across the United States. I host events and provide recovery and harm reduction services and support at public music and entertainment gatherings, in addition to my own artistry. My full-time job was working within the local health department, where I was currently providing support to the Center for Disease Control doing contact tracing and assessments with COVID patients from my home in New York, one of the epicenters for the COVID-19 outbreak. That my job had cleared me to work in the jail, and that I also worked with the drug court and in our schools. The loan officer explained to me that any arrest for a misdemeanor that occurred within the past ten years, regardless of disposition, and any arrest for a felony would permanently make me ineligible for this assistance. Not even a conviction, but an arrest. So much for due process and innocent until proven guilty. No matter what good I had done since, I would never be permitted to receive assistance during a declared state of emergency from the federal government for myself or my business. At this time there was no avenue of appeal, and I could expect to receive nothing from the federal government to support my financial distress during the pandemic.

Regarding my criminal history, I was most certainly guilty, a fact that I don't shy away from as a person in recovery. I approach my life with integrity, transparency, and honesty, something I am quite proud of at this point in my life. I've built a strong business and community reputation for myself providing services and education that I am uniquely qualified to provide because of my lived experience. I also recognized that as a person with lived experience, I must not be alone—so I called my friend Ryan Hampton. I explained to him what happened, and he explained to me the same thing had also happened to him. What's more, that he had been receiving calls from all over the country in response to this very thing from small business owners, trainers, and consultants all over the country experiencing a categorical denial for their business to remain in operations. You see, a majority of our federally qualified trainers, at least the

really good ones, work as private consultants and have their own educational firms—and many of us have criminal records.

In the weeks since this conversation has happened, I have reached out to the SBA several times to inquire about my denial. I came to learn that an appeal process had been approved, but it required me to receive a letter from the SBA explaining the reasons for my denial. I was told that I have 30 days to make an appeal or I would not be afforded the opportunity to make one. It has been weeks now since I first looked at my account to see that my loan officer had processed a denial, with no letter or communication outlining my appeals process. Phone calls to the SBA reveal that there is nothing further I can do, and nobody there can tell me if my letter was sent or when. There is a lot of uncertainty about the future of my business, the future of my loan application, and even more important things like my basic needs and housing. Before COVID-19, my salary alone was not enough to make ends meet. Like many Americans, I too have had to work multiple jobs to make ends meet. Now it doesn't look like that will be possible, with no help anywhere in sight.

Living on an island of loneliness, hopelessness, and despair is a deadly thing for someone like me—a person in recovery. Thankfully I have a robust support network and people who are creative in finding me opportunities that I can do from home to make ends meet. There still is no security or certainty for me in the foreseeable future. For others in my community, the consequences are far worse. As a recovery support professional, I'm privileged to have access to information about our local overdose rates, and I work supporting many people in recovery in our community. We've seen a recent explosion in overdose death and homelessness, overdose death with unusual common characteristics. We have for some time now seen a large number of overdoses amongst the drug using community, those getting out of jail, and people in early recovery who often experience recurrence. These are typically our vulnerable population. But recently there have been some changes that are alarming, as we are seeing increases in the number of overdose deaths—from a new population. These are most often people who have had lengths of abstinence-based sobriety—now cut off from many of their sources of support and who have experienced recent job loss and economic uncertainty.

We are seeing a different mixture of autopsy results, with some of the increases appearing more plainly to look like suicide completions, not accidental overdoses. Our overdose rates have exploded, and the people taking on the brunt of this new wave of death are not drug users but people in long-term recovery. People who have been structurally destabilized by a lack of financial alternatives and critical social supports. People like myself, who as a matter of public policy, will never be able to receive financial assistance from the federal government during a state of emergency. A government that I pay taxes to so there is money to provide such support. The end result is a cost in human lives—a cost that was already too high before COVID-19, and

in light of COVID-19, paints a particularly bleak and dismal picture for my community and our future.

The loss of such businesses for our community would cripple our ability to meet the increased need for recovery support during and post-COVID-19. In addition to exacerbating the losses experienced by our community, families, and loved ones, we will find ourselves even more vulnerable and slow to replace these essential services. In light of the future financial insecurity of government funding, there are many difficult conversations ahead about budget cuts—budget cuts that have costs in human life. Prohibiting support for small business owners in recovery is poor public policy—especially as many offender programs offer small business startups as a preferred option for seeking gainful employment upon release from prison. Individuals who now must look elsewhere for financial opportunities in a world where opportunities and funding are increasingly scarce. Businesses, like mine, that are essential for the supportive infrastructure of our community.

If we do not act now to change such policies, I fear we may lose much of our infrastructure supporting our most vulnerable people. We will continue to see massive increases in the number of overdose related deaths, as individuals who experience job loss experience recurrence at extremely high rates compared with their employed counterparts. I think often about all of the people who I had hoped to retain in employment with my $18,500 loan, considering how I could use this time to restructure my business and prepare our community for responding to the overdose epidemic that has now evolved into a deadly syndemic in light of COVID-19. Work that will either not happen, or be done without pay and with the ongoing concern of financial instability. I think about my friends and colleagues that I had hoped to retain through contractual employment during this time with those finances—how they have also been harmed by these policies. People who have done nothing wrong to deserve such denials.

I could see why so many people are relapsing and dying these days. Hope is in short supply, loneliness is everywhere, and despair is deadly. I'll continue to hold onto my faith that we will get through this. That somehow, someone, somewhere will hear my voice, and others like it, through all the chaos that has happened in the wake of COVID-19. That some decision maker will understand and have compassion for my story, see the importance of protecting businesses like mine, and choose to change these policies. If we can and do recover, then we should be given the chance to participate in the economy just the same as everyone else. If not, the consequence is jails, institutions, and death. I had begun to believe that society had started to learn from the mistakes of our past. Are we doomed to continue to repeat them? How high must the body count rise? How many more people must die? Why can't we just provide people with support during a national pandemic instead of bickering over eligibility requirements? These are questions I struggle with living in a society full of more apathy than I have ever seen in

my lifetime. Will we break free of old habits and change? I certainly do hope so. Our future as a nation depends on it.

**COVID-19 SBA Bailout Reveals Stigma of Addiction**

By Ryan Hampton

One felony can change your whole life. It's a permanent black mark on your record. No matter who you are or how you've changed since your arrest, you'll always be a criminal in the eyes of the law. Many of us in long-term recovery are still dealing with discrimination and mistreatment for something we did years ago. We're healthy now, caring for our families, and taking care of our communities. But that doesn't matter to the government. To them, a person with a felony is always going to be a second class citizen: a criminal, forever.

Michael Galipeau is a person in long-term recovery, a mentor, and a solid community partner. He's given years to helping others, trained first responders, and supported thousands of people as they walked the long road back from addiction. Yet he, like many other people, is denied the basic support guaranteed to American business and non-profit operators in a national disaster. The federal government is discriminating against the recovery community by refusing to support many of our grassroots organizations and small businesses. They condemn us to death when they remove the financial support that other businesses---including businesses that *sell potentially addictive substances to Americans*---are freely given.

How is it that bars get a bailout, but not many of our recovery community organizations? It takes *years* to build a safe space for people. The stigma of addiction makes it all but impossible to get a business loan in the first place, especially if the owner is in recovery themselves. Corporate sponsorships? Cooperation with local police groups? Forget it. By denying loans to these RCOs, the federal government is effectively strangling our community's resources and driving many people back to the vicious cycle of emergency rooms, jails, and state-run detox centers. They're guaranteeing a worse resurgence of the national drug epidemic, which affects one in three households and kills more than 300 people every day. Unlike COVID-19, people with substance use disorder aren't treated with care and respect or given long-term support so we heal without negatively affecting others. We have a high mortality rate, with less than 10 percent of people ever seeking help of any kind. Many of us are one overdose away from losing our lives.

Denying SBA loans to recovery groups sends a clear message: your lives aren't worth saving. The federal government is happy to pay the dispensary down the street to keep its doors open, but not the community center where people can gather for free recovery meetings, health information, and support with finding housing, employment, and legal help. How does that make sense?

People in recovery often have an uneasy relationship with jails, hospitals, and institutions. When you've bounced through the system long enough, it erodes trust.

Many of us learned the hard way that the stigma of addiction kills---maybe not outright with a bullet, but by strangulation. It squeezes the hope out of people, deprives them of opportunities, and diverts resources that should be fairly distributed. Across our nation, people who have given their lives to helping others recover are getting the same news as Michael. The government is saying: your efforts are not honored. You don't matter.

Just because something is legal doesn't mean it's right. Just because something is common doesn't mean it's normal. Anyone can tell you: just because one person was caught doesn't make them less guilty than their neighbor. Justice isn't equal, and it isn't blind.

We can restore the balance by raising our voices and organizing in our community. Contacting state and federal representatives and demanding the government change the requirements for small business loans ensures that RCOs and recovery coaches can keep their businesses open. Tell your elected officials that communities left behind won't survive the COVID-19 cutbacks. We won't be shut out or silenced. We have a right to do business and do what we do best: help people in recovery survive, thrive, and succeed.

**Disaster Relief and People in Recovery Commentary**

By Bill White

We are a culture of contradictions—glamorizing and aggressively promoting the consumption of psychoactive drugs (via the alcohol, tobacco, and pharmaceutical industries) while simultaneously stigmatizing and marginalizing people who experience problems related to such use.

The experience of Michael Galipeau is not unique. Social stigma against people with a history of alcohol and other drug problems has long been rooted in twin assumptions: 1) addiction is a product of weak moral character, and 2) social shunning and overt acts of discrimination dissuade people from using drugs and exert pressure on drug users to cease their drug use. When these ill-conceived strategies have failed to meet expectations, the response has been to intensify rather than abandon them, leaving in their wake a legacy of harm inflicted in the name of good.

This legacy is manifested within a history of prolonged institutionalization, invasive "treatments" (e.g., mandated sterilization, brain lobotomies, electro-convulsive therapies, toxic drug therapies), and prohibited or inhibited participation in mainstream community life. The latter is evident in the story of Michael Galipeau and so many others. We as a culture have pushed those affected by addiction into subterranean subcultures and provided few if any pathways of reentry into mainstream community life. People in addiction recovery are subjected to overt acts of discrimination as well as a broad spectrum of microaggressions.

Imagine the range of potential exclusions. You are viewed as unworthy as a friend, intimate partner, or professional colleague. You encounter obstacles in:

- obtaining housing,
- pursuing technical or collegiate education,
- qualifying for professional licensure or security clearance,
- obtaining employment, achieving work promotions,
- obtaining food subsidies,
- acquiring health and life insurance,
- obtaining insurance reimbursement for post-treatment continuing care,
- adopting or fostering children,
- acquiring child visitation or custody rights,
- attempting nearly every arena of civic participation (e.g., volunteering, voting, seeking elective office).
- And yes, like Michael, being categorically denied a small business loan in the middle of a pandemic.

Such obstacles make no distinction between active addiction and individuals in long-term recovery, forcing one to wear masks of secrecy during and after active addiction. And they are compounded for people who carry multiple stigmas, e.g., women, people of color, members of the LGBTQ community, persons with disabilities, and members of other historically marginalized groups.

Unsuccessful addiction recovery attempts have as much to do with these stigma-influenced environmental obstacles as they do intrapersonal obstacles to recovery. How can one achieve recovery when denied access to community spaces in which people in recovery are welcomed and valued? Grassroots recovery advocacy organizations have attempted to address the issue of social stigma for more than two decades, and notable efforts have been made to put public faces and voices to the recovery experience. Michael Galipeau's experience is one more call to go beyond attitudinal change to dismantle the machinery through which addiction-related stigma has been institutionalized for more than a century. It is time to dismantle the scaffolding through which stigma produces specific arenas of discrimination.

The dismantling of discriminatory structures will involve multiple strategies.

**Recovery Representation**: Intensifying efforts to assure the inclusion of people in recovery (and authenticity and diversity of recovery representation) within key legislative, regulatory, and funding decision-making venues.

**Data Collection**: Amassing data on the prevalence of specific areas of discrimination and the effects of such discrimination on individuals, families, organizations, and the community at large. Such data collection would involve both numerical data and personal stories drawn from diverse communities of recovery. This could encompass survey data and case studies collected by local recovery community organizations as well as scholarly studies. Mechanisms are needed for reporting and redressing acts of discrimination.

**Education and Contact Strategies**: Including community-based, stigma-influenced obstacles to recovery in the public presentation of our recovery stories. Using data and personal stories to education the public and professional communities regarding the negative effects of addiction-related discrimination on people seeking and in recovery as well as the positive effects that could accrue from community inclusion.

**Protest Strategies**: Exposing discriminatory practices through public acts of protest—traditional and social media exposés, public protests, economic boycotts, political lobbying, etc.

**Legal Redress**: Working with the Legal Action Center and other organizations to mount legal challenges against acts of discrimination against people in addiction recovery. These could take the form of individual suits as well as class action suits.

Yes, it is time the recovery advocacy movement moves from changing attitudes about addiction and recovery and begins the work of systematically dismantling the institutional mechanisms through which stigma is actualized in overt acts of discrimination. Michael Galipeau's story has a kaleidoscope of variations across the U.S. and beyond. It is up to us to write the final chapters of such stories. Excluding people from the social, economic and political life of a community exacts a high toll, as illustrated by a recent study linking the closure of automotive assembly plants to rising rates of opioid overdose deaths. As a country, we have paid that price for far too long.



# 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. (2020). Recovery after the pandemic. Posted at www.williamwhitepapers.com

## Recovery after the Pandemic

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The novel coronavirus pandemic will exert profound effects on the future of addiction treatment and recovery. Predicting such effects risks casting one more a fool than prophet, but those concerned about the future of recovery need to anticipate as clearly as possible the challenges and opportunities that will flow from the present pandemic. Earlier essays in this series predicted the futures of drug use, addiction treatment, recovery support, and the future of AA, NA, and other recovery mutual aid organizations. The pandemic will accelerate many of these earlier predictions and alter others.

Whether the coronavirus pandemic will be as transformational to the recovery community as the AIDS epidemic was to the LGBTQ community remains unclear. The long-term effects of the COVID-19 pandemic will depend on three factors:
1) reach (the ultimate depth and scope of international and national penetration),
2) severity (cumulative morbidity and mortality combined with the magnitude of economic, social, and political disruption), and
3) duration (including the question of whether COVID-19 is an isolated milestone event or the awakening of more lethal and cyclical pandemics).

Based on my own projections of its reach, severity, and duration, I predict ten critical effects of the coronavirus pandemic on the future of addiction recovery.

*Recovery support needs will increase as direct and indirect consequences of the pandemic. As the stabilizing effects of daily work routines diminish or cease in response to demands for social distancing, drug use and its consequences will accelerate among those at greatest risk for substance use disorders, including for those in pre-clinical stages of such disorders. In addition to "telescoping" problem progression, a new population of at-risk individuals will emerge in tandem with pandemic-related self-medication of emotional distress, social isolation, financial distress, family conflict, and grief.

*Recovery support service needs will intensify due to closure of local addiction treatment programs. Treatment organizations who lack cash flow to survive rapid reduction in service delivery and related income streams will be particularly vulnerable for closure. Such closures will

place greater pressure on recovery communities to respond to acute needs, much as they did prior to the proliferation, professionalization, and commercialization of addiction treatment in the 1970s and 1980s.

*The movement of recovery support to a *primarily* digital culture will increase exponentially. If the COVID-19 pandemic extends for an extended period or morphs into a cyclical pattern of reactivation, this shift will rapidly solidify. Such is already underway as older generations of people in recovery give way to generations born with hands grasping digital devices. Telemedicine approaches to addiction treatment will expand rapidly and move the locus of addiction from institutional settings to the digital world, e.g., "treatment without walls." All manner of recovery support media will move to digital platforms. The platforms, formats, and timing through which addiction treatment and recovery support will be delivered in the future will evolve rapidly. Breakthroughs in technology will create once unimaginable space for digital recovery communities. The present and future pandemics will speed the transition of recovery communities into that space.

The COVID-19 pandemic drives home two powerful lessons: no viable program of personal recovery can rely solely on support within face-to-face meetings, and no recovery fellowship is sustainable as an organization based solely on face-to-face meetings. Studies have shown that participation in multiple aspects of recovery mutual aid groups elevates recovery outcomes far superior to those achieved from meeting attendance alone. At no time is that more important than in the middle of a pandemic. The critical question is the extent to which recovery support activities beyond online meetings can be co-located in digital space, e.g., reading recovery literature, home group activities, receiving and providing sponsorship, service activities, daily application of program principles, drug-free socializing, and so forth.

The movement of recovery support to e-recovery platforms may occur so quickly that important limitations and unintended consequences of such platforms will not be visible for some time, including the fate of individuals and organizations left behind in this shift. (Watch for forthcoming blog on this question.)

*The economic impact of the coronavirus pandemic will be far greater and more prolonged than presently anticipated, which will extend the historical focus of recovery communities on emotional and social recovery support into the arena of financial mutual aid. Recovery community organizations will become more deeply involved in providing food, clothing, shelter, mutual economic assistance, and employment assistance. The potentially sustained economic austerity spawned by the pandemic may force substantial cuts to public funding for addiction treatment and recovery support services. As the availability of local services declines or collapses, recovery advocates will begin the long-term process of rebuilding such services and developing alternative service and support models that tap the spirit of volunteerism that has long existed within communities of recovery.

*The strong service ethic within communities of recovery will be extended in more formal ways to address the larger needs of the community. This may take the form of a Recovery Corps through which volunteerism of people in recovery is channeled to address a broad spectrum of community problems and needs. These service initiatives will be delivered primarily through new grassroots recovery community organizations rather than traditional recovery mutual aid societies. Such activities will formalize broader acts of service already evident in response to the pandemic.

*Increased international contact among people in recovery sharing digital recovery support platforms and improved digital language translation technologies will

contribute to the rise of a global recovery community. These pandemic-spawned contacts will lead to the international hybridization of recovery-related concepts and the cross-fertilization of recovery support initiatives, e.g., sharing of recovery support models and recovery support literature and international recovery conferences unaligned with any recovery fellowship. These contacts may spur ecumenical recovery support frameworks that defy easy categorization as secular, religious, or spiritual.

*Increased knowledge of public health concepts and technologies will spur increased interest in population-based interventions to prevent and mitigate alcohol and other drug problems across the spectrums of severity, complexity, and chronicity. This could lead to greater balance between environmental and personal recovery support strategies. (Watch for forthcoming blog.)

*The elevated status of scientists and science-grounded professional helpers emerging from the pandemic will spur increased expectations for research reporting on methods of addiction treatment and recovery support. The dissemination of such findings will result in the public exposure of, and a backlash against, highly promoted products and services confirmed in studies to be unhelpful or harmful. In the post-COVID world, objective facts will be much more likely to take precedence over ideological spin or marketing hype. The pandemic's new revelation: opinions on matters of health not grounded in science can be deadly. Technical expertise matters.

*The coronavirus pandemic's exposure of the weaknesses of the U.S. healthcare system will accelerate demands for health care reform—reforms that will potentially exert profound effects on the future of addiction treatment and recovery support. These reform processes will result in the integration of addiction treatment within primary health care or lead to the increased isolation and marginalization of addiction treatment and recovery support. Such opportunities and threats require the presence and active participation of recovery advocates in these policymaking forums.

*When the viral dust settles and the body count is complete, the health disparities between Black and White and between the wealthy and poor and working class people will expose a wrenching reality. This will bring renewed and heightened attention to disparities within the addiction treatment and recovery support arenas in such areas as problem prevalence, service attraction/access, service retention, and recovery-focused service and support outcomes. Every professional and peer intervention will be expected to account for who they are reaching and not reaching and the effects of proffered services across diverse populations. The pandemic retrospective will underscore that need.

Change can be as regressive as progressive, and change always carries the shadow of unintended consequences. We must move gently into the brave new world that is upon us, taking care that we do not abandon long-held core values in our efforts to survive.

Based on what you have observed in your local community, what predictions would you revise or add to this list?



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**Citation**: White, W. & Stauffer, B. (2020) The Digitalization of Recovery: Supporting those Left Behind. Posted at www.williamwhitepapers.com

## The Digitalization of Recovery: Supporting those Left Be

Bill White and Bill Stauffer

Recent essays predicted the effects of the COVID-19 pandemic on the future of addiction recovery and celebrated the resilience of communities of recovery as they transitioned from face-to-face to online recovery support meetings. This brief article calls attention to those potentially left behind in this transition to digital support and explores the ethical and effective implementation of digital recovery support platforms. Such support will be crucial if physical distancing mitigation measures are prolonged or if the COVID-19 pandemic morphs into cycles of dormancy and reactivation.

### Transition Problems

The transition from face-to-face to e-recovery support platforms occurred so quickly, it was not possible to engage recovering people in the design and implementation of new or expanded recovery support platforms. To achieve an inclusive recovery community, we must be mindful of persons or communities for whom virtual platforms are unavailable or unsuitable. To achieve the maximum range of person-platform fit, we must insist on engagement of diverse recovery communities in the design, implementation, and evaluation of these new resources. PRO-A in Pennsylvania provides an example of standards for the delivery of ethical and inclusive e-recovery support in its 10 Assurances statement.

**Problems of Access** In our celebration of the explosive growth of online meetings and other virtual recovery supports, we should not forget those who lack access to such platforms. These include people who are homeless, people in rural and frontier communities who lack reliable internet access, people who cannot afford internet access, and people who have relied on public libraries and other facilities for internet that are now closed to the public. Many older adults in recovery and others who lack knowledge and skills in navigating online resources may also be potentially lost in the digital transition. Communities suffering "diseases of despair" long before the arrival of the COVID-19 pandemic could experience amplified consequences of limited digital recovery support access. We must keep such communities in mind as we seek to expand recovery support resources.

**Problems of Comfort** Studies to date reveal that digital recovery support is particularly attractive to women, youth, people with

mobility challenges, status-conscious professionals, people with social anxiety, and people lacking regular access to face-to-face recovery support meetings. Those who find digital recovery support less attractive include people who tend to resist anything new, those fearing online technology, and those who fear embarrassment or humiliation due to their lack of sophistication with such media. People in recovery who purposely choose to live a digital free or digital limited lifestyle may be particularly vulnerable when faced only with digital recovery support options.

We have a lot to learn about the brave new world we are entering. It may take some time before we know the size of this "digital-discomfort" population, but attraction to and comfort with e-recovery support will likely wane to some degree as its novelty wears off and access to face-to-face meetings returns. The potential size of populations using digital recovery support as a primary recovery support mechanism compared to those who use digital recovery support as an adjunct to face-to-face meetings remains unclear. The proportion of people who find the quality of digital support equivalent or superior to face-to-face meetings compared to the proportion who find the quality of the digital recovery support experience inferior to face-to-face encounters remains a critical recovery research question.

Recovery support comes in multiple media, including one-on-one communication, group interactions, print resources, and video/audio media. Successful recovery often involves combining and sequencing multiple activities across the stages of long-term recovery. The key for each person is to find a stage-appropriate fit between themselves and those ingredients that best serve to strengthen recovery initiation, maintenance, and enhanced quality of personal and family life. At a systems level, the key is to increase recovery prevalence within affected populations by assuring the broadest possible menu of recovery support options.

**Problems of Vulnerability** New e-treatment and e-recovery support media, like all digital media, raise privacy and security concerns. Digital media can be tools of manipulation, exploitation, or harassment. Examples of such include "13th stepping" (using online contact as a means of sexual seduction of the most vulnerable help-seekers), unauthorized disclosure of shared information, stalking, bullying, and exposure to hate speech. Financial exploitation is also possible via exposure to unethical advertising, collection and monetization of personal information of those using online recovery support platforms, and excessive fees or appeals for financial contribution.

As we expand digital forms of counseling and support, we need to explore how we can protect those receiving such services and supports. In the delivery of e-counseling services, we must assure that the protections built into face-to-face counseling (e.g., informed consent, confidentiality, delivery of evidence-based practices, clinical supervision, standards of ethical practice, etc.) are not lost within the e-counseling process. In the delivery of peer recovery support, we must make group values, communication guidelines, and member expectations as transparent as possible (e.g., anonymity, crosstalk policies, etc.) at the outset of participant involvement and use our collective conscience as a guide to refine online recovery support norms and etiquette.

**E-Recovery Limitations and Side Effects** The transition from face-to-face to online recovery support has inherent limitations and potential risks. Much could be lost in this transition, such as pre- and post-meeting socializing, reduced depth of sharing from some and oversharing for others, erosion of sponsorship relationships to brief text

exchanges, serial virtual performances without the sense of real connection and closeness, and a reduction or loss of service activities linked to face-to-face meetings. There is a danger that large online meetings will expand our number of recovery connections while reducing the number of people with whom we have particularly close communication.

When humans connect, something vital happens that brings us together in a powerful manner. The recovery experience often involves feeling understood by and connected to an entire room of people. We are only beginning to understand the science behind how and why these connections occur. As this paper on autonomic mimicry and neurocognition suggests, one key element may be that we experience emotional contagion. Body language, eye contact, and the subconscious sharing of information between humans underpins the process of emotional contagion—this feeling of being connected. The digital medium available to us today may be limited in its capacity to transmit such subtle information and may result in a less powerful sense of connection. As we develop digital recovery platforms, we need to understand what we can do to bridge the gaps in current technology to enable recovery-inspiring connections.

As creatures of excess, there is also the risk of seduction into this digital world (e-addiction)—a risk enhanced by the now infinite number of online meetings and the advent of marathon meeting formats. Hyper-connection could result in an erosion of social skills and our comfort with face-to-face communication. The risk would be abandoning the work of recovery in the real world in exchange for self-absorption in the e-universe. And of course, there are the risks of hacking, ZOOM bombing, and digital fatigue.

The future of e-recovery support hinges to a great degree on the pace of improvements in the technologies used in these media and the development of ethical guidelines to govern their operation.

**E-Services within Larger Systems of Care and Support** How will the rapid expansion of e-treatment and e-recovery support services effect larger systems of care for substance related problems? One concern is that funding authorities facing pandemic-spawned economic austerity may cut funding for traditional face-to-face services. The rationale for such action would likely be that online services cost less with many provided by peers in recovery rather than by paid service professionals. The depletion or loss of existing service elements would be particularly detrimental to those who benefit most from combinations of intensive professional and peer-based support—those with the most severe, complex, and chronic substance use disorders. E-recovery support should represent an expansion rather than a contraction of choices within the service menu.

Digital support combined with available medical and psychosocial support may help us move our care systems to better aid the processes of long-term personal and family recovery. We know that 85% of us who are able to sustain recovery for five years stay in recovery for the rest of our lives. Digital support services may well augment and extend our current care strategies in meaningful ways to help more of us reach that critical five-year benchmark mark.

## Reaching Those at Risk of Being Left Behind

Digital recovery is a cool—low touch--medium of communication. Our challenges are how to warm it up to fit the existing culture of recovery and how to reach people who are unable or uncomfortable making the transition to these new recovery support

media. Below is a summary of what we envision as possibilities.

*Including the voices of people in recovery in all decisions related to the design and conduct of digital recovery support platforms
*Providing digital devices to people in recovery who cannot afford them
*Workshops and one-one-one tutoring by recovery community organizations on mastering online recovery support media
*Providing online access via recovery community centers
*Greater reliance on recovery literature, including manual-guided recovery protocol replete with personal recovery stories
*Renewed and expanded access to earlier-era resources, e.g., recovery talks on cassettes and CDs
*Expanded availability of e-counseling services (e.g., telephonic or video counseling)
*Smaller face-to-face meetings with modified meeting rituals (using physical distancing precautions)
*Home visits by recovery coaches (using physical distancing precautions)
*Telephonic recovery check-ups and telephonic recovery support meetings facilitated by recovery coaches
*Expanded recovery literature distribution
*Use of traditional mail service for recovery support communications
*Expanded use of recovery magazines and newsletters as vehicles of recovery support
*Creating and communicating consensual ethics and etiquette of online recovery support
*Creating ethical guidelines for organizations hosting e-counseling and e-recovery support services, and
*Creating ethical complaint and disciplinary mechanisms for e-recovery support services.

It remains unclear whether the surge in digital recovery platforms will attract and sustain the attention of the majority of people seeking recovery support meetings once the novelty of these new resources wears off and access to face-to-face meetings returns. It also remains unclear how the quality of the recovery meeting experience will evolve within these new platforms. The challenges we face include how to warm up e-recovery support (e.g., telehugs in the telehealth recovery space) for those capable and comfortable with such platforms, how to facilitate and support people making the transition from face-to-face to digital recovery support, and how to assure that we do not lose people in the transition into what may be a predominately digital future.

The key is that we engage the digital champions, the digital doomsayers, and everyone in between with viable recovery support choices. We must aspire to a recovery standard that supports all pathways of recovery, all platforms, all modes of recovery, and all people who seek recovery. The future is not at all clear in respect to e-recovery support, but what is clear is that it will be an increasingly visible platform of recovery support. What is not clear is how effective and authentic it will be and who it will include and exclude. The answers to those questions are up to us.

Eddie, D., White, W. L., Vilsaint, C. L., Bergman, B. G., & Kelly, J. F. (2021). Reasons to be cheerful: Personal, civic, and economic achievements after resolving an alcohol or drug problem in the United States population. *Psychology of Addictive Behaviors.* Advance online publication. https://doi.org/10.1037/adb0000689

## Abstract

**Objective**: Alcohol and other drug (AOD) use disorders impose a prodigious personal and societal burden. While most remit, little is known about the achievements accrued as people accomplish and sustain addiction recovery. Greater knowledge regarding the nature and prevalence of such achievements, when such achievements occur, what factors influence accrual of achievements, and how such achievements relate to other indices of functioning would support treatment and policy planning, and may instill hope for individuals and families seeking AOD problem resolution.

**Methods**: Nationally representative, cross-sectional survey of United States (US) population of persons who have overcome an AOD problem (*N* = 2,002), assessing individual factors and achievements in 4 domains: self-improvement; family engagement; civic, and economic participation. Logistic and linear regression models tested theorized associations among variables.

**Results**: Most (80.1%) achieved at least one achievement associated with the 4 domains. A linear monotonic relationship was observed with greater achievements accruing with greater time in recovery. Accrual of achievements after AOD problem resolution was related to racial minority status, more education, earlier age of substance use initiation, illicit drugs as primary substance used, more years since resolving AOD problem, more psychiatric diagnoses, lower psychological distress, and regular 12-step program attendance. Multiple regression analyses found greater total achievements were independently associated with greater self-esteem, happiness, quality of life, and recovery capital.

**Conclusions**: Most individuals achieve an increasing number of achievements with time since AOD problem resolution, and these are associated with gains in measures of well-being that may support ongoing AOD problem remission, and recovery.

White, W. & Galanter, M. (2021). InTheRooms.com: Profile of an innovative digital addiction recovery support network. Posted at www.williamwhitepapers.com

# InTheRooms.com:

# Profile of an Innovative Digital Addiction Recovery Support Network

William L. White, M.A.[1] and Marc Galanter, M.D.[2]

*Abstract*

A surging recovery advocacy movement, the rise of new recovery support institutions, and advancements in digital technologies set the stage for the birth of online digital recovery support platforms that have experienced explosive growth during the coronavirus pandemic. This paper profiles InTheRooms.com (ITR), the largest of the digital recovery support platforms. The review includes ITR's history, service and support menu, methods of operation, and the membership profile of its more than 840,000 members.

## Introduction

Specialized resources to support the resolution of severe alcohol and other drug (AOD) problems have existed in the United States for more than 200 years.[3] Until recently, these resources consisted primarily of information and referral centers, addiction treatment organizations, and secular, spiritual, or religious recovery mutual aid organizations.[4] Several seminal events set the stage for the emergence and dramatic growth of new recovery support institutions.

The 2001 recovery summit in St. Paul, Minnesota marked the formal launch of a "new recovery advocacy movement" aimed at culturally and politically mobilizing people in addiction recovery and their families and allies. Organizational leadership of this movement rested with national recovery advocacy organizations (e.g., Faces and Voices of Recovery, Young People in Recovery, the Recovery Advocacy Project, the African American Federation of Recovery Organizations, etc.) and local recovery community organizations (RCOs). These national and local recovery organizations are historically distinct from earlier AOD-missioned organizations.[5]

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The goals of the new recovery advocacy movement included:

- shifting the central focus of the AOD arena from a problems focus (addiction pathology and clinical intervention) to a solution focus (the lived experience of long-term personal and family recovery),
- creating new grassroots recovery support institutions focused on recovery advocacy and peer recovery support,
- creating the physical, psychological, and social space in local communities in which recovery can flourish,
- reducing the social stigma and related discrimination attached to addiction and addiction recovery, and
- increasing scientific research on the prevalence, pathways, styles, and stages of long-term addiction recovery and the relative effectiveness of recovery support resources.[6]

The new recovery advocacy movement helped fuel numerous parallel developments, including:

1) the national and international growth and philosophical diversification of recovery mutual aid organizations (RMAO),[7]
2) RMAO development for people experiencing "process addictions", e.g., compulsive destructive behaviors related to gambling, food, work, money, relationships, or sex,
3) extension of addiction treatment from ever-briefer models of acute care to models of sustained recovery management nested within larger recovery-oriented systems of care,
4) emergence of an ecumenical culture of recovery and recovery cultural production in the arenas of language, music, art, theatre, film, photography, fitness, sport, adventure, and entertainment,[8]
5) a collective sense of mutual identification and "peoplehood" of individuals and families traveling quite different pathways of recovery, and
6) the rise of new recovery support institutions[9] (recovery community centers, recovery residences, recovery high schools and collegiate recovery programs, recovery-friendly businesses, recovery ministries, recovery

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cafes, recovery book clubs, and recovery-focused sports and adventure venues) and new recovery support roles (e.g., recovery coaches).[10]

The exponential growth of new recovery support institutions included the growth of online recovery support platforms and the exponential acceleration of participation in these platforms during the coronavirus pandemic.[11] Scientific studies affirming the value of peer recovery support services and online resources in enhancing long-term recovery outcomes elevated the professional and public credibility of these new mechanisms of recovery initiation and maintenance.[12]

A significant milestone in the emergence of online recovery support platforms was the founding of InTheRooms.com (ITR) on October 6, 2008. ITR is a free digital recovery community hosting more than 160 live online recovery support meetings per week along with the provision of other recovery support information and services. The purpose of this brief paper is to outline the history of InTheRooms.com, review its scope of services, and describe the profile of its online participants. The review includes information obtained through interviews with ITR cofounders and internal ITR data shared with the authors.

## InTheRooms.com

History ITR was co-founded by Ronald Tannebaum and Ken Pomerance. Both in long-term addiction recovery, Tannebaum's professional background was in sales, marketing, and sports promotion, and Pomerance brought decades of entrepreneurial experience in marketing, sales, and business development.

At the time of ITR's founding, few online social networking platforms existed where people seeking recovery support could meet and have access to timely information and mutual recovery support. Tannebaum and Pomerance's founding vision for ITR was to "give recovering addicts a place to meet and socialize when they're not in face-to-face meetings." ITR was initially conceived as a "Myspace or Facebook for

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recovery" for people from diverse pathways of recovery—a safe and secure location where one's personal anonymity could be protected. The vision was one of respecting but transcending fellowship "brand loyalty" (e.g., AA, NA, CA, WFS, SMART Recovery, LifeRing, etc.) by creating a broader identity and social support medium for "people in recovery."

The early challenges faced in launching ITR were numerous. First was accessing the technology that could make the founding vision possible. The original ITR platform included only chat rooms and discussion boards. ITR added formal recovery support meetings to the platform in 2012-2013 when technical advancements made such a meeting platform possible.

A further challenge involved communicating the availability of ITR. Growth was slow at first with most site promotion through word-of-mouth and face-to-face marketing. Encouraging ITR participation also required establishing ITR credibility as a legitimate, secure, and safe recovery support site. It took some time for people to realize that the mission of ITR was one of recovery support and not making money from people seeking such support.

An unexpected challenge for ITR was working out language that would encompass all pathways of recovery while facilitating brand identification within the website. Universal recovery language (e.g., "recovery") was used to describe the overall site, but once a person expressed preference for a particular mutual aid fellowship, then communications with that person reflected the language preferences of particular recovery communities (e.g., "sober" for AA, "clean" for NA, etc.).

Throughout this process, efforts were required to assure the long-term financial viability of ITR. The co-founders and a small circle of investors, many of whom were people in recovery or family members affected by addiction, provided the initial financial resources to launch ITR. ITR income streams eventually came to include rent for the meeting rooms paid by each group, income from advertising, and fees for assistance with research studies and surveys. These income sources support continued site maintenance, site development, and the four part-time contractual staff who oversee tech management of ITR.

Present Scope of Services The ITR website currently provides access to more than 160 online recovery mutual aid meetings per week; access to recovery-focused blogs, articles, podcasts, and speaker tapes; information on health, exercise, nutrition, mental health, and relationships; a Recovery in the News update; and linkage to local face-to-face recovery support meetings, addiction treatment, and recovery coach resources.

ITR hosts meetings of more than 40 different recovery mutual aid groups. The most frequent online meetings are AA (69 meetings per week) and NA (30 meetings per week) and other Twelve-Step groups (e.g., Cocaine Anonymous, Marijuana Anonymous), but ITR also hosts:

- family-centered support meetings (e.g. Adult Children of Alcoholics, Al-Anon, Nar-Anon, Co-Dependents Anonymous),
- faith-based meetings (Life Recovery, Recovery Dharma),

- secular recovery support meetings (e.g., Atheists & Agnostics AA & NA, LifeRing Secular Recovery),
- meetings for women (She Recovers, Women in Recovery, Women Warriors),
- LGBTQ meetings (e.g., NA Pride, Pride in AA),
- occupational meetings (e.g., Nurses Helping Nurses),
- meetings focused on recovery from related problems (e.g., Gamblers Anonymous, Sex Addicts Anonymous, Sex and Love Addicts Anonymous, Dual Diagnosis Anonymous, Overeaters Anonymous, Chronic Pain Anonymous, Trauma & Recovery, Coronavirus Support Group),
- culturally-grounded meetings (e.g., Wellbriety),
- Men's Meetings / Spiritual Gangster
- Yoga in Recovery
- Healthy Love, and
- NAMI / Mental Health / National Alliance for Mental Illness.

ITR hosts marathon meetings during holidays and during significant weather events in which people have limited access outside their homes.

When members register, they may express preference for one or more recovery mutual aid meetings. At present, 346,000+ members have expressed a preference for AA, 223,000+ for NA, with other groups garnering between 27,000 and 1,600 expressed preferences.

In The Rooms experienced dramatic increases in membership beginning in March, 2020—from a pre-pandemic average of 200 new member registrations per day to more than 2,500 per day. There was also exponential growth in the number of people participating in each online meeting, with some meetings reaching as many as 500 members in attendance. In response, ITR extended meeting times to give more participants time to share, added new meetings, and created marathon AA and NA meetings that run from 9 am to 10 pm on weekends. In a recent week (September 2021), the number of participants per meeting ranged from 49 to 421.

Membership Profile As of October 2021, ITR has a membership of more than 840,000 from more than 135 countries. The present (October 2021) membership growth rate is 8-10,000 new members per month. ITR members attend an average of 3.1 online meetings per week on the ITR platform.

Of ITR members who identified their gender at point of registration, 58.2% were female, 41.7% were male, and less than 1% were transgender. The years in recovery varied considerably, with ranges of recovery time displayed in Table 1.

**Table 1: Years In Recovery of ITR Members**

| | |
|---|---|
| Less Than One Year | 2.9% |
| 1-5 Years | 27.2% |
| 6-10 Years | 30.4% |
| 11-50 years | 39.5% |

Connecting with or Referring Individuals to ITR Joining ITR is quite easy. All that is required is to establish an account and then click "Video Meetings" at the top of the page to select a meeting you wish to join. Members have the choice of receiving a daily email with a listing of all available meetings that day. ITR members can remain anonymous as they choose, including using a pseudonym, an avatar, or a silhouette for their name and image. For members needing confirmation of meeting attendance, there is also a mechanism on ITR that allows for such meeting verification related to potential court or workplace mandates. Further information on membership registration is available by clicking InTheRooms.com.

## Discussion and Conclusion

A new recovery advocacy movement has fueled the growth of new recovery support institutions and the exponential growth of online recovery communities. The latter include online recovery support meetings sponsored by local recovery mutual aid fellowships, but it also includes a wide variety of websites that deliver recovery-focused information and recovery support services. InTheRooms.com is the largest online recovery platform measured by size, diversity, and geographical reach of its membership. ITR reflects a growing ecumenical culture of recovery that embraces multiple pathways and styles of recovery and that caters to the needs of individuals and families across the long-term stages of personal and family recovery.

Online recovery communities confirm the growth of recovery support options outside the arenas of addiction treatment and face-to-face recovery mutual aid meetings. Such forums serve as both an adjunct and alternative to traditional recovery support resources and are part of growing attempts to expand indigenous recovery spaces/landscapes, including virtual spaces, within local communities. Evaluation efforts to date suggest that these resources can enhance recovery initiation and stabilization, recovery maintenance, and enhanced quality of personal and family life in long-term recovery.[13] Such resources may be particularly important for historically marginalized populations, individuals lacking access to face-to-face recovery support meetings, and individuals who experience social anxiety, safety, or stigma-related concerns when considering face-to-face recovery support options.[14]

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# Recovery Space in Educational Settings

William L. White



# Remarks Prepared for Collegiate Recovery Day and the 2021 ARHE/ARS/AAPG Conference


## William L. White, M.A.

### Emeritus Senior Research Consultant, Chestnut Health Systems


Good morning. I have been asked to share a few reflections on the rise and evolution of recovery high schools and collegiate recovery programs. I regret that advancing age, health challenges, and pandemic restrictions prevent me from being with you in person.

After more than two centuries of worldwide preoccupation with alcohol- and other drug problems, we are finally entering the age of recovery. This jarring shift in attention from pathology to the positive transformation of individuals, families, and communities is evident in many quarters. We are witnessing:

- The growth and international dispersion of secular, spiritual, and religious recovery mutual aid organizations,
- The exponential growth of online recovery support resources, now accelerating in the wake of the COVID19 pandemic,
- The emergence of resistance, resilience, and recovery as new organizing concepts at policy and service practice levels led by increased representation of people in recovery within these venues,
- Efforts to extend acute care models of addiction treatment to models of sustained recovery management nested within larger recovery-oriented systems of care,
- The expansion of peer recovery support services as adjuncts or alternatives to professional treatment,
- The exponential proliferation of new recovery support institutions: recovery community organizations, recovery community centers, recovery residences, recovery support within educational settings, recovery industries, recovery ministries, recovery cafes, recovery music festivals, and recovery adventure and sports venues,

- Mass public recovery advocacy and recovery celebration events attended by thousands of people.
- Sophisticated recovery-focused political lobbying, and
- A dramatic increase in recovery-focused research studies and the number of scientists devoting themselves to recovery research.

These and related innovations are the downstream effects of the cultural and political mobilization of people in recovery and their allies. The emergence of a new recovery advocacy movement and an ecumenical culture of recovery reflects an important historical shift. People from diverse pathways of addiction recovery are identifying themselves as “a people” with a distinct history, shared needs, and a linked destiny. As this movement transitions beyond mass mobilization and institution building, it is pushing recovery-friendly policies and practices within the arenas of law, government, health care, popular and social media, religion, business, entertainment, and education.

Recovery high schools and collegiate recovery programs are an important part of these larger shifts. They will continue to focus on their unique blend of peer-based recovery support and academic achievement, but they will increasingly extend their missions in three specific areas. First, advocacy of recovery-supportive campus/community policies and practices will rise as an increasing focus. Second, efforts will intensify to expand the physical and social space in which recovery can flourish in both campus and community environments. Third, they will extend their student support focus to the development of recovery studies as an academic area of concentration and assert recovery as a topic of legitimate scientific research. We see in these projected trends a move to transcend clinical models that focus on intrapersonal changes in thoughts, feelings, and behaviors to ecological models that focus on creating healthy environments that elicit hope and healing. The former offers a vision of personal transformation; the latter envisions campuses and communities in which recovery is welcomed and supported.

Historically, experiential knowledge and professional/scientific knowledge have existed as two separate worlds within the alcohol and other drug problems arena. Collegiate recovery support programs and recovery studies curricula offer a potential bridge of integration between these two worlds. The future of recovery will be profoundly influenced by such integration as it will by the shift from a narrow focus on personal support to creating the physical, psychological and social space in which recovery can flourish. Many of you will be the vanguard in this movement to bring recovery to the very heart of wounded institutions and communities.

We are at a precarious time in our national and international history. Our very culture has been wounded and is in need of recovery. As people in recovery and allies of recovery, we can play important roles in this cultural healing by conveying the lessons and values of recovery. This is what we know. Self-absorption can be diminished through open acknowledgement of one’s imperfection. The masks of grandiosity can be shed and replaced by genuine humility. Distortions of reality, projection of blame, and

scapegoating can be shed when we openly accept our brokenness, embrace our common humanity, strive for honesty with self and others, and assert personal responsibility. Personal and collective amends can mitigate past sins of omission and commission. Personal and collective excesses can give way to greater balance and harmony—from competition and conflict to compassion and care. Bitterness and resentment can give way to forgiveness and gratitude. Preoccupations with power and control, close-mindedness, and aggression can give way to tolerance, mutual identification, and mutual support. Anguished self-absorption can give way to connection to community, shared joy, and laughter. Sanctuaries can be created where people actually listen to one another without interruption or condemnation. These are among the lessons of recovery. It is time we extended our healing efforts with each other to healing the wounds of the communities and cultures we are seeking to re-enter.

Earlier generations in recovery missed this larger calling. In those years, most people entered recovery later in life and spent years healing the wreckage of the past with little time left to embrace this greater mission. Today, people are entering recovery with decades to live their lives in health and service. Education-based recovery programs are preparing a vanguard of people in recovery who have an unprecedented opportunity. Many years ago I penned an essay referencing the work of mythologist Joseph Campbell in which he noted a common structure to heroic tales: the hero's departure, the hero's transformation through great trials, and the hero's return to share the fruits of their experience. I likened the experience of addiction and recovery to these three acts, but raised the question of whether we as people in recovery had fully returned home or whether we returned to hidden closets within our communities. We have reached the time when we can and must return home.

Some of you listening to these words may not realize it, but you were born for this moment in time—born to serve as a catalyst of healing not just for individuals and families, but for whole communities and cultures. As an old man nearing the end of my own recovery ministry, I envy what lies ahead of you as you seek such a destiny. Know that you are the fulfillment of the dreams of people in recovery who came before you. We rest well knowing the baton is now in your hands. We wish you Godspeed on this journey into the future of recovery.

Bill White is Emeritus Senior Research Consultant at Chestnut Health Systems, past-chair of the board of Recovery Communities United, and a volunteer consultant to numerous recovery community organizations. A person in long-term recovery, he has a Master's degree in Addiction Studies from Goddard College and has worked in the addictions field since 1969 as a streetworker, counselor, clinical director, trainer, and research consultant. Bill has authored or co-authored more than 400 articles, monographs, research reports, and book chapters, as well as 21 books. His books include *Slaying the Dragon – The History of Addiction Treatment and Recovery in America, Alcohol Problems in Native America, Addiction Recovery Management,* and *The History of Addiction Counseling in the United States*. He is also the author of more than 340 recovery blogs. Bill's sustained contributions to addiction recovery have garnered awards from more than 20 of the field's leading organizations.

**Addiction Recovery:**

**A Selected Bibliography of**

**Professional Publications and Scientific Studies**

**(Updated June 2022)**

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**Edited by Rita A. Chaney, MS, LMHC**

## Introduction

This topical bibliography is intended as a supplement to a recovery management monograph series developed through the sponsorship of the Center for Substance Abuse Treatment's Great Lakes Addiction Technology Transfer Center, the Institute for Research Education and Training in Addiction, and the Philadelphia Department of Behavioral Health and Intellectual disability Services. (This series can be downloaded from www.williamwhitepapers.com.)

What I have tried to do in this bibliography is capture scientific and professional papers specifically related to addiction recovery or that provide insights into the prevalence, pathways, processes, pathways, styles, and stages of addiction recovery. The primary emphasis is on studies and papers published in leading peer-reviewed scientific journals. It is hoped this will help interested readers locate classic and contemporary papers related to the resolution of alcohol and other drug problems. Future updates of this recovery research bibliography will be under the auspices of the Recovery Research Institute: https://www.recoveryanswers.org/

The bibliography is organized topically under the following headings:

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**Toward a Recovery Paradigm**

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**Recovery Definition**

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**Spirituality and Addiction Recovery (Also see Frameworks of Addiction Recovery)**

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**Recovery in Communities of Color & Other Diverse Populations**

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**Recovery in Rural Communities**

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**Remission via Deceleration of Alcohol and Other Drug Use (Also see Style of Recovery Initiation / Moderation Management)**

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**Peer Recovery Support Services (and Social Network Effects on Recovery)**

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**People in Recovery as Volunteers**


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**Recovery and Employment**


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**Health Status of People in Recovery**

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**Smoking (Nicotine Addiction) and Addiction Recovery**

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**Addiction as a Chronic Condition Requiring Sustained Recovery Management**

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**Recovery Management and Recovery-oriented Systems of Care**

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**Recovery High Schools & Collegiate Recovery Programs**


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**Precovery: Efforts to Work with or Organize Active Drug Users**

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**Strategies for Breaking Intergenerational Cycles of Addiction**

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## ABSTRACT

The transition from jail to community is a high-risk time for individuals experiencing substance use disorders (SUD), with elevated risks of overdose and other substance-related harms, as well as high recidivism rates and re-incarceration. Gains made from successful treatment in prison are often lost in this transition.The current paper evaluates this process for one justice programme, Chesterfield HARP, a Therapeutic Community based in the Chesterfield County jail that continues supporting former inmates through their release by examining engagement and retention rates and changes in recovery capital among incarcerated individuals before incarceration and after transition to recovery housing in the community. Adult prisoners (both male and female) who engaged in the Chesterfield HARP programme completed an assessment of recovery capital (REC-CAP instrument) while in prison and following their transitions to one of a number of local recovery residences with strong links to the prison programme (ensuring continuity of care and support). The results suggest successful bridging with positive growth across multiple recovery capital domains. The study provides further evidence for the importance of continuity of care and integrated models of strength-building and recovery-focused interventions in successfully bridging the transition from prison to the community for offenders with a SUD history.

Belanger, M. J., Sondhi, A., Mericle, A. A., Leidi, A., Klein, M., Collinson, B., Patton, D., White, W., Chen, H., Grimes, A., Conner, M., De Triquet, B. & Best, D. (2024, in press). Assessing a pilot scheme of intensive support and assertive linkage in levels of engagement, retention, and recovery capital for people in recovery housing using quasi-experimental methods. *Journal of Substance Use and Addiction Treatment*, https://www.sciencedirect.com/science/article/abs/pii/S2949875923003351

## Abstract

Introduction

Strong and ever-growing evidence highlights the effectiveness of recovery housing in supporting and sustaining substance use disorder (SUD) recovery, especially when augmented by intensive support that includes assertive linkages to community services. This study aims to evaluate a pilot intensive recovery support (IRS) intervention for individuals (n = 175) entering certified Level II and III recovery residences. These individuals met at least three out of five conditions (no health insurance; no driving license; substance use in the last 14 days; current unemployment; possession of less than $75 capital). The study assesses the impact of the IRS on engagement, retention, and changes in recovery capital, compared to the business-as-usual Standard Recovery Support (SRS) approach (n = 1758).

Methods

The study employed quasi-experimental techniques to create weighted and balanced counterfactual groups. These groups, derived from the Recovery Capital (REC-CAP) assessment tool, enabled comparison of outcomes between people receiving IRS and those undergoing SRS.

Results

After reweighting for resident demographics, service needs, and barriers to recovery, those receiving IRS exhibited improved retention rates, reduced likelihood of disengagement, and growth in recovery capital after living in the residence for 6–9 months.

Conclusion

The results from this pilot intervention indicate that intensive recovery support, which integrates assertive community linkages and enhanced recovery coaching, outperforms a balanced counterfactual group in engagement, length of stay, and recovery capital growth. We suggest that this model may be particularly beneficial to those entering Level II and Level III recovery housing with lower levels of recovery capital at admission.

Bell, J. S., Hagaman, A., Beattey, J., Fears, G., White, W. L., & Watson, D. P. (2025). Advancing peer support workforce research: Insights and recommendations through the lens of professionalization. *Journal of Substance Use and Addiction Treatment*, 170, 209612. https://doi.org/10.1016/j.josat.2024.209612

## Abstract

Over the past two decades, peer support providers have increasingly formalized their roles in the addiction treatment workforce through credentialing and professionalization efforts. Despite these advancements, misconceptions regarding their professional identity persist and contribute to challenges such as burnout and high turnover. This commentary underscores the importance of viewing the peer workforce as an emerging profession using a lens that has previously been applied to other healthcare service roles. We outline key milestones in the peer workforce's professional development and ongoing labor advocacy efforts by state and national organizations. We call for a comprehensive research agenda that addresses workforce outcomes, workplace dynamics, and role competencies. Such efforts are crucial for advancing the recognition and support of peers as an integral component of the behavioral healthcare workforce.

**Citation**: Best, D., Duffy, S., Smith, D., Bryson, J., & White, B. (2025). An “outside in” model of recovery capital growth: building personal and social recovery capital from community resources. Addiction Research & Theory, 1–11. https://doi.org/10.1080/16066359.2025.2523825

## Abstract

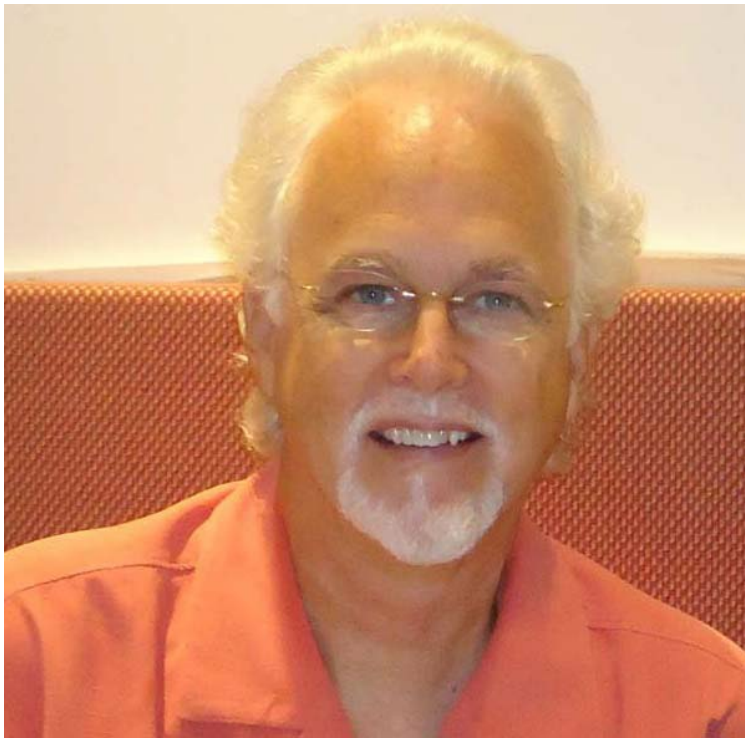
Recovery capital has been defined as the breadth and depth of internal and external resources available to individuals to support their recovery journey. It is seen as a strengths-based phenomenon involving the dynamic growth across three domains – personal, social and community. In this paper we argue that the primary model of growth is ‘outside-in’ and so, particularly for those individuals with low (or negative) levels of baseline personal/family and social capital and high levels of problem severity/complexity/chronicity, the starting point for intervention is through community capital – those resources and assets that create the conditions for social and then personal capital growth. In this paper, we outline a conceptual framework for how this happens, using the example of Recovery Oriented Systems of Care and Inclusive Recovery Cities to demonstrate not only how this approach can create the conditions for individuals to grow their recovery capital but that the ultimate aim is to contribute to overall community wellbeing through creating a model of ‘reciprocal altruism’ and building collective efficacy across communities and across diverse cultural contexts. We supplement this with some examples from Middlesbrough, the first UK Inclusive Recovery City.

Bunaciu, A., Sondhi, A., Best, D., Hennessy, E. A., Best, J., Belanger, M. J., Leidi, A., Grimes, A., Conner, M., De Triquet, R., & White, W. (2025). Longitudinal Changes in Recovery Capital Among Recovery House Residents With and Without Criminal Legal System Involvement: A Marginal Structural Modeling Analysis. *Criminal Justice and Behavior*, *0*(0). https://doi.org/10.1177/00938548251359584

**Abstract**

Individuals with a history of criminal legal system (CLS) involvement may experience additional challenges to their recovery from substance addiction. We compared recovery capital trajectories of individuals in recovery residences with and without the involvement of CLS and assessed predictors of their Overall Recovery Capital Score (ORCS). We employed a quasi-experimental approach using weighted repeated measures modeling to compare the ORCS on the REC-CAP measure between 1,933 residents from 101 recovery houses (RH), with (59.9%) and without (40.1%) CLS involvement. Residents with CLS involvement showed equally positive gains in recovery capital while in recovery residences ($p < .0001$), despite reporting greater unmet needs at baseline. Being man ($p = .01$) and older age ($p = .04$) predicted greater recovery capital gains regardless of CLS status. Our findings suggest that RH may be an effective setting for individuals with CLS involvement to build their recovery capital.

**The Coproduction of a Recovery Evidence Base on the Frontiers of Future Recovery Research**
**Frontiers of Recovery Research Series –** *William White Interview with Bill Stauffer*



What an honor it is in my life to do this interview. I think the first time I ever heard the name William White was when I read the book Pathways from the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals (1996). It validated a lot of my own experience and influenced my perspectives on my efforts to support the transmission of recovery in the community I lived in. His tireless work has had similar influences on many people and how we see and support recovery here in the US and beyond. It made logical sense to me to incorporate an interview with him in this series that generated out of a paper he wrote in 2024 focused on coproduction of recovery process.

That paper was titled Frontiers of Recovery Research. In April of 2024, I had the distinct honor of being asked by Bill to present his words in that paper as the keynote to open up the first annual NIDA Consortium on Addiction Recovery Science (CoARS) conference. It is one of his most important writings. It should serve as a blueprint for the future of recovery research in America. One of the challenges we have suffered for at least the last six decades is a deficit focus on addiction instead of a resiliency and recovery orientation. His paper properly orients future research efforts on long term recovery and resiliency. This series of interviews is intended to build on his paper and include key figures in research and the recovery community to imagine what we need to accomplish moving forward.

The 12 domains Bill White addressed in his Frontiers of Recovery Research paper include, the Definition & Measurement of Recovery, the Neurobiology of Long-Term Recovery, Incidents and Prevalence of Recovery, Resolution and Recovery Across the Severity Spectrum, Pathways and Styles of Recovery Across Diverse Geographical / Cultural / Religious Contexts and Clinical Subpopulations, Recovery Across the Lifecycle, Stages of Recovery, Social Transmission of Recovery, Family Recovery, Recovery Management & Recovery Oriented Systems of Care, New Recovery Support Institutions, Service Roles and Recovery Cultural Production and Flourishing / Thriving in Recovery.

In this interview with Bill, I hope to highlight the value of experiential knowledge as a way of knowing and its importance on both shaping clinical and scientific knowledge in the arena of recovery research and applying all forms of knowing into recovery supportive strategies across all of our communities. To increase insight on the need to ground future recovery research in the three spheres you wrote about including the adequacy of Recovery Representation (beyond token inclusion), the authenticity of Recovery Representation (avoiding “double agentry”) and the diversity of Recovery Representation (demographic, cultural, & recovery pathway diversity) if we are to move efforts forward effectively. And finally to consider examples that exist in respect to collaborative and co-productive recovery focused research that yielded important results. Processes that were intentional about being set up and conducted in this way, or conversely where efforts have failed historically because they were not designed and conducted in this manner.

William (“Bill”) White has a master’s degree in Addiction Studies from Goddard College and has worked in the addictions field since 1969 as a streetworker, counselor, clinical director, trainer, researcher, and prolific author. Bill has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 21 books, including *Slaying the Dragon – The History of Addiction Treatment and Recovery in America; Let’s Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement;* and *Addiction Recovery Management: Theory, Research, and Practice* (co-edited with Dr. John Kelly).

For the past 30 years, his work has focused on mapping the prevalence, pathways, styles, and stages of long-term addiction recovery. Bill's sustained contributions to addiction treatment and recovery in the United States have been acknowledged by numerous awards from such organizations as the National Association of Addiction Treatment Providers, the National Council on Alcoholism and Drug Dependence, NAADAC: The Association of Addiction Professionals, the American Society of Addiction Medicine, the American Association for the Treatment of Opioid Dependence, Harvard Medical School Department of Psychiatry, Faces and Voices of Recovery, Young People in Recovery, and the Association of Recovery Schools. Bill's collected papers can be found here.

- **Bill, in your 2024 paper Frontiers of Recovery Research, you wrote about the importance of coproduction and collaboration of recovery focused research to ensure that experiential knowledge of recovery in all of its diversity is foundational to all future focuses of recovery research efforts. Are you aware of research that was successful in contributing to our knowledge and to recovery efforts because they were intentional about coproduction and collaboration with recovery community?**

*There are examples from the relatively recent past of researchers working with community and service entities to inform and improve recovery transmission efforts. The work that George Deleon did to explore and define the facets of therapeutic community in order to understand and expand its evidence base was a good example of coproduced evidence base that valued experiential knowledge. Readers can find his books and writings such as Community as Method: Therapeutic Communities for Special Populations and Special Settings (1997) and see the evidence for therapeutic communities in supporting recovery in these care settings. An earlier example is that of EM Jellinek and his efforts to understand the progression of alcoholism and phases of recovery from alcoholism through surveys to members of Alcoholics Anonymous in the mid-1940s.*

*In our current era, I see the work of Dr. John Kelly and colleagues at the Recovery Research Institute Dr David Best and his colleagues in exploring both the quality of life of recovery communities and the positive impact of recovery in their lives and in the vitality of their communities in such studies as the 2015 Life in Recovery Survey. Similar collaborative surveys developing the evidence base around the value and prevalence of recovery have been conducted in Australia (2015), in Canada (2017), and across the European Union (2024). We are learning about the transmission of recovery and its benefits here in the US and in the areas delineated here, yet we know next to nothing about recovery in vast parts of the world, including South America, Africa, large portions of Eurasia and the Pacific. In the long measure of history, we have made progress in shifting from a pathology orientation to a recovery orientation, but we have a very long way to go.*

*There are the contributions of Marc Galanter, M.D., Professor of Psychiatry at New York University School of Medicine (NYU) and founding director of its Division of Alcoholism & Drug Abuse and his research on mutual-aid recovery fellowships, including Narcotics Anonymous (NA) / Narcotics Anonymous World Services (NAWS). He was the lead author on Scientific Studies on Narcotics Anonymous (2020) examining what the peer-reviewed literature says about NA's effectiveness, accessibility, and scope and highlights the efficacy of mutual aid programs.*

*The research that has been the most beneficial to our communities historically has done so authentically, designed and facilitated in ways that respect the autonomy of these recovery communities, honors their singleness of purpose, and is conducted with integrity and scientific rigor. Can we consider for a moment what we may find if we embarked on surveying recovery internationally in ways that uncovered both the commonality of the processes as well as the diversity of experience globally? In the mapping of recovery around the world, we have vast uncharted territories in which much needed knowledge is needed. For readers considering dedicating time and effort to the pursuit of this knowledge moving forward, you would be pioneers on the global frontiers of recovery.*

- **Bill, there is perhaps no person alive who has invested as much time and energy as you in understanding recovery history in America and how to expand it. How important has experiential knowledge been in the various movements across history / why is it vitally important to consider experiential knowledge in any future recovery research through implementation, evaluation and application to real world conditions?**

*As a recovery historian, I see that across several generations, we have experienced cycles of valuing and devaluing experiential knowledge within the addiction treatment field, a field that itself originated from experiential knowledge. You recently wrote a piece with Dr Enid Osborne about Dr Thomasina Borkman and the Social Model of Recovery. Dr.*

*Borkman is a hero of mine. Her papers, including her early work on Experiential Knowledge: A New Concept for the Analysis of Self-Help Groups (1976) were very influential on how my perspectives developed. In the era when I got in the field (1960s), 80% of the field was comprised of people in recovery; by the end of the 2000s, it was less than 30%. Our field devalued recovery in order to pursue commercial success and professionalism and there were significant consequences to our collective efforts as a result. It is the cycle we keep repeating.*

*You asked me also about when that cycle of devaluing people in recovery and experiential knowledge started, and I would have to say it began in the late 1980s with the advent of managed care. As managed care processes gained momentum in the early 1990s, treatment episodes became ever-briefer, in part because there were no organized groups that effectively pushed back against these constrictions in services that meant life and death for hundreds of thousands of us across the nation. Around the same time, the field experienced an escalation of credentialing expectations. The treatment field grew out of experiential knowledge and passion to serve and in the early 1990's shifted from experiential to academic knowledge even though the latter offered little preparation for the management of long-term recovery.. First was the expectation of an undergraduate degree and then the expectation of a graduate degree. When the field lost its recovering workforce, there was broad dissatisfaction and disillusionment on the part of our indigenous communities of recovery on what our treatment systems were producing via recovery outcomes. That dissatisfaction led to the shift that occurred as a result of the new recovery advocacy movement to change the focus of the field from one of pathology to a greater recovery orientation.*

*To get back to your primary question on why it is vital moving forward to develop more collaborative and co-productive recovery focused research, it is important to understand how little we actually know six decades into research efforts on addiction and recovery. We still have not focused nearly at all on life and death issues that millions of people in recovery grapple with routinely. There is despair over matters that research could shed important light on in ways that impact our lives but has largely failed to focus on so far.*

*There are three I can highlight off the top of my head:*

1. ***Does the recovery of an addicted parent lower the SUD risk that of their children or increase their odds of recovery from such a disorder?*** *People in stable, long-term recovery are concerned about intergenerational addiction and recovery rates. They worry about the likelihood of their kids becoming addicted at greater prevalence than the general public. They want to know what they can do to improve the odds in preventing their children from becoming addicted. Related to this question is our lack of knowledge about how their own recovery may influence recovery processes for their kids if they do become addicted. Can the recovery of a parent, both parents or even siblings and extended family members support earlier initiation of recovery processes for family members who do become addicted? The answers to these questions matter a great deal to millions of people in recovery. We lack minimal evidence-grounded answers for these families.*

2. ***What is the risk of breakup of an intimate / marital relationship following recovery initiation?*** *For generations, we have experienced a dynamic in which marriages and unions survive addiction and the ravages and deleterious erosion of trust and communication over many years and then fail as the addicted spouse gains a foothold in recovery. What factors influence this far too often unspoken dynamic? While we have the groundbreaking work of Stephanie Brown and Virginia Lewis into family recovery and their developmental model of family recovery (1998), we have done scant little to develop a rigorous knowledge base on the need for external, structural support systems for all family members during the recovery process. We have a sense that it relates to internal familial structures of support being too unstable and that additional scaffolding may improve outcomes, yet the answers on how to build these and the timing of such supports remain largely a mystery.*

3. ***What factors lead to addiction recurrence after prolonged remission and how can such remission be best reinstated in such circumstances?*** *We lack even a rudimentary understanding of how recovery unfolds over years or decades and risk factors across the life cycle. What does recovery look like over the lifespan for early life initiates? What does it look like for midlife initiates? For those in sustained mid-life recovery? How can we tailor efforts to people that can improve their recovery odds dependent on where they are in the life cycle? We know almost nothing about these questions. Experiential knowledge of recovery communities needs to be tapped on such vitally important questions.*

*Also, we have for decades witnessed incidence in which people in long term, stable recovery, people who are often paragons within our community who then relapse in late-stage recovery. We have almost no data on what influences this outcome or what it may take to reestablish recovery for these beloved members of our community. We know little from the standpoint of science about people who often have dedicated significant portions of their lives to helping others only to later find themselves falling back into the depths of addiction. Again, this is a life and death matter for thousands of people, and it simply has never made the research agenda for our institutes of knowledge. We should ask critical questions about why we lack this kind of information at this juncture. Consider that Max Glatt first published the Jellinek Curve in 1958. It has been nearly 70 years since we first had a formulation of recovery stages and yet we still lack rudimentary knowledge of key facets of recovery across the lifecycle despite billions of dollars of research money that has principally been focused on understanding our pathology, but not our resiliency.*

*Of particular interest to me as I approach age 79 is how recovery unfolds and the processes of sustaining recovery in the final stages of life. Many in long term, stable recovery face particular challenges as we age. There are so many facets of life that create risks to recovery in later life. Pain becomes a more constant companion as we age, and this presents risks for us not present in the general population. Recovery has a strong interpersonal dynamic, and in later life our social networks are pruned, and isolation often grows. People in later life often struggle with loss of work identity and their sense of purpose. All of these things can be exacerbated by the tendency for people to relocate geographically in later life. Our sponsors and close recovery community supports, those we looked towards for support, have died off and we may experience a vacuum of support. We may not be connected to, or even identify with younger generations of people in recovery. If one stands back and sees how on one hand our society has embraced recovery as we stood up to be counted as viable members of our communities over the last generation and yet we then reflect on how little we know about these inevitable processes, it really highlights how very far we have to go before recovery is authentically valued on a societal level.*

*You asked me why it is so vitally important to consider experiential knowledge in any future recovery research through implementation, evaluation and application to real world conditions. We need to do so because it has not occurred substantively in meaningful ways to date. We have to ask ourselves and our institutions some hard questions about how generations of people in recovery and their families have lived and died and yet we still lack fundamental knowledge on matters that are life and death for our community. Perhaps as we move forward with the next iteration of a recovery movement, we shall get our institutions to prioritize the very things that millions of people in recovery grapple with day in and day out. One thing seems certain to me, if we do not raise these issues, no other group will.*

- **Looking forward twenty years, where would you hope we are at in respect to our co-productive and collaborative recovery research? How do we get there?**

*To consider the answer to that question we have to understand what authentic representation actually looks like beyond the illusion of inclusion. I see three major facets to recovery representation requisite to co-productive and collaborative recovery research.*

1. ***Adequacy of Representation** – Our systems typically think of recovery representation as a minimalist process. Gather the academic and industry stakeholders and then add in Joe from the local AA meeting and pronounce that the recovery community is represented. That is illusion of inclusion. The token person may have scant insight in any of the processes beyond his or her own recovery and yet is expected to represent the width and depth of all people in recovery. Adequacy of representation is not tokenism but includes people in proper numbers and in ways that positively influence the design, implementation and interpretation of what is being studied. This is not the norm for our recovery research standards now, but it should be the standard for the future.*

2. ***Authenticity of Representation** – As a historian considering progress and challenges to successive recovery movements over the course of time, we have long had people who, while in recovery had other agendas that far too often derailed movement objectives. I have called these persons confederates in some of my writings and also referred to the associated dynamic as "double agentry." Among other places I have reflected on this, we wrote about this together in 2022 in the Reflections on Recovery Representation piece. If you have a bunch of people in the room who are in recovery but they have other interests, be it business or personal gain, they are in essence double agents,*

*ostensibly there representing recovery but in reality, having far different and often hidden agendas that history shows us risks cooptation and cultural appropriation of our collective efforts. This is inauthentic recovery representation, and it is unfortunately quite common. For us to move a recovery centric research agenda forward, we must have authentic representation focused on recovery as their sole agenda.*

3. ***Diversity of Representation*** *– When we consider diversity of representation, this goes beyond the traditional demographic considerations of age, ethnicity, socioeconomic backgrounds and similar considerations but also include diversity of recovery pathways from traditional mutual aid, faith based, medication supported, SMART Recovery and a myriad of others. We cannot expand our knowledge base in respect to the diversity of pathways and recovery experiences without the inclusion of people from across the spectrum of experience.*

*We need to consider representation moving forward, anything less than full inclusion of our communities becomes window dressing to paternalistic models that have dominated our treatment systems over the last several decades. Beyond that, we need to understand and document our history in all of its diversity. One of the things that brings me hope is that in recent years a lot of people are contacting me as they consider the recording and preservation of various facets of our history. There are groups working to preserve NA and AA history, not just in the broad sense but at the community level, as they record living history before it is lost. There are efforts to document the history of Smart Recovery, and of course your efforts to continue to record the history of the new recovery advocacy movement. There are people working to do similar work in states and localities. Such efforts can serve to remind us and inform us of our rich history and the value of broad recovery representation moving forward.*

- **In respect to that question, what progress have we made in the last twenty years? What in your estimation has driven the progress or hindered forward momentum? Why is this an important facet?**

*There are several areas in which we have made very real progress. One of those domains is in understanding how common recovery is within the broader community. Readers today may not fully understand that in the 90s, two decades after the rise of modern addiction treatment, we still had no idea what recovery prevalence looked like across the U.S. So the work of Dr Deb Dawson and her colleagues at NIAA on the Correlates of recovery from alcohol dependence (2012) began to develop this knowledgebase. Additional groundbreaking work was done by Dr John Kelly and his colleagues work on the prevalence and pathways of recovery from drug and alcohol (20170, As well as Dr Wilson Compton NIDA and his colleagues at NIDA Prevalence and correlates of ever having a substance use problem and substance use recovery status (2020). Nearly all of the work done prior to the era in which these papers came out were focused on the pathology of addiction. Understanding how common recovery is, where it is found and how it flourishes in our communities is the foundational work to build a knowledge base on how to expand recovery transmission efforts moving forward. We should commend their efforts as recovery research pioneers and build on it.*

*We also see the work of Dr David Best and his pioneering work on recovery capital, including community level recovery capital as he focused on the transmission of recovery in communities. He examined how recovery spreads in communities and that recovery carriers can get "better than well", that is to say that as a result of recovery in their own lives, they had become better versions of themselves than they would be had they never become addicted and gotten into recovery. His work Community recovery as a public health intervention: The contagion of hope (2017) greatly extended our knowledge about how recovery is fostered and transmitted in and across communities, often independent of formalized treatment efforts.*

*As I spoke about earlier in respect to the surveys on recovery and quality of life in recovery, while we now have a foundational understanding of recovery prevalence, the mapping of recovery and only an inkling of how recovery is being transmitted in community, this knowledge is limited is largely limited to the US, the UK and Canada. It is also limited to adult communities. We lack information on recovery in adolescent populations, transitional age youth and communities of color.*

*Readers should consider our progress and the pioneers that have cleared a basic path forward, but much more needs to be done. Decades into these efforts to expand recovery efforts through an informed evidence base and yet we lack really basic information to derive care and support future interventions on. For younger readers considering a career focus,*

*there are so many things one can work on in ways that would be of profound service to developing a more complete recovery evidence base.*

*Another area in which we have just scratched the surface on has been the defining of recovery. The first organized attempt to define recovery was initiated with the Betty Ford Consensus Panel in 2007. We know that the term recovery can describe a process, a state and even for many an identity. It is also true as I have asserted over the years that there are significant commercial and political interests in the defining of recovery. We need to consider all of these complexities as we look at the efforts since 2007 to define recovery. While important work has been accomplished as our understanding of all the nuances and complexities are considered, all this work is from my view leading us towards defining and measuring recovery in meaningful ways. We are not there yet, but all of the effort to date has been necessary to the defining of recovery, from remission and problem resolution to the additive qualities that are often characteristic of recovery for millions of people.*

*We have made significant progress in developing an understanding of styles of recovery transmission, Dr. Katie Witkiewitz at the University of New Mexico has contributed greatly to our insight non-abstinent problem resolution and insight into overall well-being, quality of life, and the absence of substance use-related problems, rather than just the absence of the substance itself as we consider de-escalation of use as a desired clinical outcome for some people.*

*One of the things I reflect on as I consider the progress we have made in respect to developing a recovery evidence base is my recovery research bibliography which I started to compile in 2010. At that time, it was around 15 to 20 pages in length. Much of what it contained in respect to recovery outcomes was extracted from designs focused on treatment outcomes. That bibliography has dramatically expanded and is now approaching 500 pages in length and more centrally focused on recovery.*

- **So what do you see as opportunities moving forward?**

*We are just beginning to see the proliferation of new recovery pathways and recovery support institutions, including Recovery High Schools, Collegiate Recovery Programs, Recovery Community Centers, Recovery Cafes and active recovery programs, Digital Recovery Support Platforms, alternative mutual aid programs across the continuum of secular to diverse faith communities. These are some of the things that sprouted out of our efforts to expand multiple pathways of recovery. Despite this inspiring proliferation, we do not understand some really fundamental facets. We have made some progress in evaluating their efficacy, but I suspect we are just scratching the surface in understanding how they support recovery across the ecosystems they operate within. Questions like:*

- *In respect to peer services, is recovery status a factor in effective peer services? There are peers in recovery and peers not in recovery; does it matter in respect to the outcome? If so, how much of a difference is there?*
- *As I spoke about earlier, we have made little relative progress in family recovery – there was greater interest in this era in the late 1980s and the 1990s than there is in this era, and the topic deserves significant focus.*
- *We know that there are some people who are essentially recovery carriers, they have qualities that pull people they encounter into recovery. We also have people in recovery who by the nature of predatory practices for self-gain push people away and cause harm to our efforts. How do we consider the personal factors in whether a person is a recovery carrier or instead one who does harm in the name of help? What is the critical knowledge base? What is the fundamental skill set? What role does temperament and emotional intelligence play in effective recovery transmission on the interpersonal level? We need to know more about these factors if we are to become more effective in our efforts.*
- *We know how various trajectories as people initiate recovery. Efforts can start in hospital settings, traditional addiction treatment settings, recovery centers and a variety of other venues. What are the differences in these trajectories? Which ones are most effective with which people under what conditions? All this matters if we are to being to develop nuanced models of support that get people to what we may anticipate they may need, providing the most likely positive outcome. We simply do not have that data and we desperately need it.*
- *There has been minimal at best focus on the analysis of the new recovery advocacy movement, its impact, its current status and future potential. We need to more fully understand the role of the movement as a systems level change agent. It has not benefited from such an examination.*

*I am really interested in why some people flourish in recovery and go well beyond just altering their relationship with drugs. What does 'better than well' entail? Are there ways we can help nurture so that more people develop these qualities? What makes some people recovery carriers? If we think of recovery as a community transmissive process that saves lives and heals communities, how do we foster the development of the recovery contagion in the broad diversity of our communities?*

*We also need to be much more methodical in our efforts and plan for longer term strategies. A generation ago when I first started to highlight recovery management and recovery-oriented systems of care models there was a flurry of activity around these concepts. Treatment and funding systems went and hired a peer worker and called themselves recovery oriented. They were still very much acute care focused. Fundamentally nothing had changed beyond the optics as recovery was the flavor of the day. So many groups reached out to us and began citing our research on recovery management and recovery-oriented care as they embarked on rebranding as recovery oriented. There was almost never a follow up focus beyond the initial recovery branding. Some others criticized us for setting the bar too high in insisting we initiate long-term recovery models. Even in that era, I understood that a lot of the work we were doing was not to inform and change the system of care in that era but to sow the seeds for a future generation of effort. I see some of your writings in this light too. We are tilling the ground for long term change; recovery is not the flavor of the month but a foundational paradigm. I suspect that these facets will be incorporated in the next iteration of a recovery movement.*

- **Last question – Where are the nodes of recovery we can anticipate playing a critical role in the coproduction of moving forward into the next generation?**

*We are seeing recovery thrive in so many spaces. There is a vast, largely untapped reservoir of creativity and capacity for expressing and celebrating recovery across all of our communities. One area I see the greatest potential is through the vehicle of creative expression. Perhaps our greatest opportunity is through the processes of self-expression and cultural production in the arenas of language, literature, art, music, theatre, film, and public recovery celebration events. I see a world where recovery community organizations collaborate with arts communities to expand opportunities through creative expression. Arts can change the world!*

*Through these processes, people can express and communicate the positive facets of recovery as a community level healing agent. 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 including the arenas of creative expression. There are reasons that people turn to the arts in times of difficulty or to communicate vital facets of the human condition. This is why I envision so many opportunities when I look beyond the horizon of my own life. What I see is that future generations are going to contribute greatly to recovery efforts. They will be part of a process that stretches back for several generations and forward across the millennia. When one considers our efforts in this context, there is only progress, setbacks are fleeting. Recovery always finds a way.*

*Ultimately when I look into the future, we are going to need to develop solutions that mirror the complexity of the problems we face. When I started my career decades ago, treatment was the focus in version 1.0 of recovery efforts. We have developed beyond that initial two-dimensional pathology oriented acute care model in ways that have created an array of options and entry points in respect to the initiation of recovery. We have some ways to go to develop longer term recovery support models. One of the limiting factors I see in our era we will need to expand beyond is that of seeing treatment as the primary structure of healing.*

*Even as we have built beyond version 1.0, the design and operating systems of our models remain treatment centric. A 2.0 system would be built on recovery. One of the primary reasons for this is we have focused on commercial structures within a medical care orientation. I believe that 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. Treatment is just one tool in our toolbox. Those of you here may well determine whether this is a random, intuitive, or science-guided process.*

*It is my hope that in the not-too-distant future we will have a 2.0 multi-dimensional system in which treatment is not at the center of the operating system but rather the proliferation of recovery through social manners of transmission and community grounded metamorphic processes as the operating system and the heartbeat of our future systems of care. I would love to see it in the next ten years. If in ten years we are not there yet, do not despair. It will occur.*

*One of my key takeaways from our history is that the community will form movements to carry us forward. It is the constant in our history. We will do this. I am abundantly optimistic. When I say we, I mean all of us living, those who come after us and all those in the past across our long and unfinished history. We, together have contributed and will continue to support the emancipation from addiction and metamorphosis of recovery. The gifts that recovery promises in our own lives, in the lives of our family and loved ones and in the communities, we contribute to. We are part of a long game, and it is one in which we will ultimately prevail. Of this I am certain.*

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## Abstract

This chapter builds on the introductory conceptual chapter by Granfield and Cloud by reviewing the processes through which the concept of recovery capital gained traction in a range of policy and practice settings and, in particular, how it became operationalised and quantified in a range of measurement tools. The chapter outlines the network of influence and impact of the recovery capital concept and its dissemination first nationally and then internationally reported through the lived experiences of first William White and then David Best, prior to concluding with a review of the trajectory of learning and research in this space, and some personal reflections on likely future directions of work around recovery capital and its measurement.

# The Family Recovery Capital Framework

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# Overview

In 2024, Adfam published their report "Above and beyond" highlighting the positive experiences of family support people in recovery recounted across various key stages and domains of their recovery journey. Families matter. Yet this comes at a cost – to the person in recovery in terms of feelings of shame, stigma and guilt, and for the families often at huge emotional, financial and psychological distress. Addiction is a form of trauma for families and the recovery process charted for those overcoming their own addictions is much more weakly conceptualised and evidenced in terms of the recovery journeys of whole families. In this paper, we use data from three different research projects, including the Adfam report, to generate a model of holistic family recovery – the Family Recovery Capital Framework (FRCF).

# Background and rationale

STAR Recovery has partnered with three organisations in preparation of this report in an attempt to deploy the framework for recovery capital to families. Recovery capital has been defined as "the breadth and depth of internal and external resources" available to support an individual in their recovery journey (White, & Cloud, 2008, p.1). The recovery capital model has been increasingly used as the metric of recovery support services to demonstrate the growth in strengths individuals experience in their recovery journey. Our goal in this project is to utlilise that approach – strengths-based, holistic and inclusive – to improve our understanding of recovery as a family concept. This is based on the idea that addiction is a form of trauma that impacts not only individuals but whole families, and that the family will have its own journey, which can be viewed as a form of post-traumatic growth, related to but separate from the recovery journey of the individual with the addictions issues.

# Methods

For this programme of work, the STAR Research team worked with three organisations all of whom are committed to providing a holistic and strengths-based approach to helping individuals and families overcome addiction problems:

**Adfam** (https://adfam.org.uk) is the leading charity in England for all the millions of people affected by someone else's drinking, drug use or gambling. In 2024, Adfam had published its "Above and Beyond" report based on the role families played in supporting recovery journeys, as reported by people in recovery. We used a secondary analysis of that dataset for this project, based on a survey of 90 people who described themselves as "being in recovery or recovered".

**PROPS Family Recovery Service** (https://props.org.uk) provides support to people whose lives are affected by someone else's drug and alcohol use in two areas of the North-East of England- Newcastle and North Tyneside. Data were drawn from a service evaluation of the PROPS Family Recovery Service in Newcastle and North Tyneside conducted by STAR Recovery involving secondary analysis of routine data collection around client wellbeing and focus groups with the board of PROPS, staff and people who used their services in both areas.

**Recovery Connections** (www.recoveryconnections.org.uk) provides recovery support services in seven areas across the North-East of England and is a founding member of the College of Lived Experience Recovery Organisations. Recovery Connections commissioned STAR Recovery to conduct a needs assessment to measure the level of provision and need of support for affected others in Middlesbrough. A survey was completed by service users, capturing family composition, and family support needs supplemented with focus groups across residents of the residential rehabilitation service, online participants, women's groups, community members, and Recovery Connections staff.

What is presented below is a brief overview of the findings from each study followed by a synthesis into an integrated model for a Family Recovery Capital Framework (FRCF).

# Adfam Findings

Adfam: Of the 90 respondents, 72 (80%) reported at least one family member involved in their recovery, while 18 (20%) indicated minimal or no family support. Among those with family involvement (*n* = 72), support was multidimensional. Emotional encouragement was most commonly reported (80.6%), followed by practical help (55.6%), housing assistance (40.3%), childcare (38.9%), and financial contributions (52.8%). There was also a pronounced gendered pattern in caregiving roles. Mothers were the most frequently cited source of support (54.2%), followed by female partners/ex-partners (29.2%), followed by sons (26.4%), fathers (25%) daughters (22.2%) and sisters (22.2%).

However, the qualitative data suggested that family involvement was not always seen as universally beneficial, particularly in the early stages of recovery, with one respondent reporting that it "Made things worse. Lack of understanding". There was also evidence that, while there was a need for family support, it was rarely accessed — only 22.2% of participants reported that their family had accessed structured education about addiction. Among families without structured support (75%, with 2.8% unsure), 78.8% indicated they would have liked it, and 86.5% believed it would have helped.

**78.8%** without structured family support would have liked it, with **86.5%** believing it would have been beneficial!

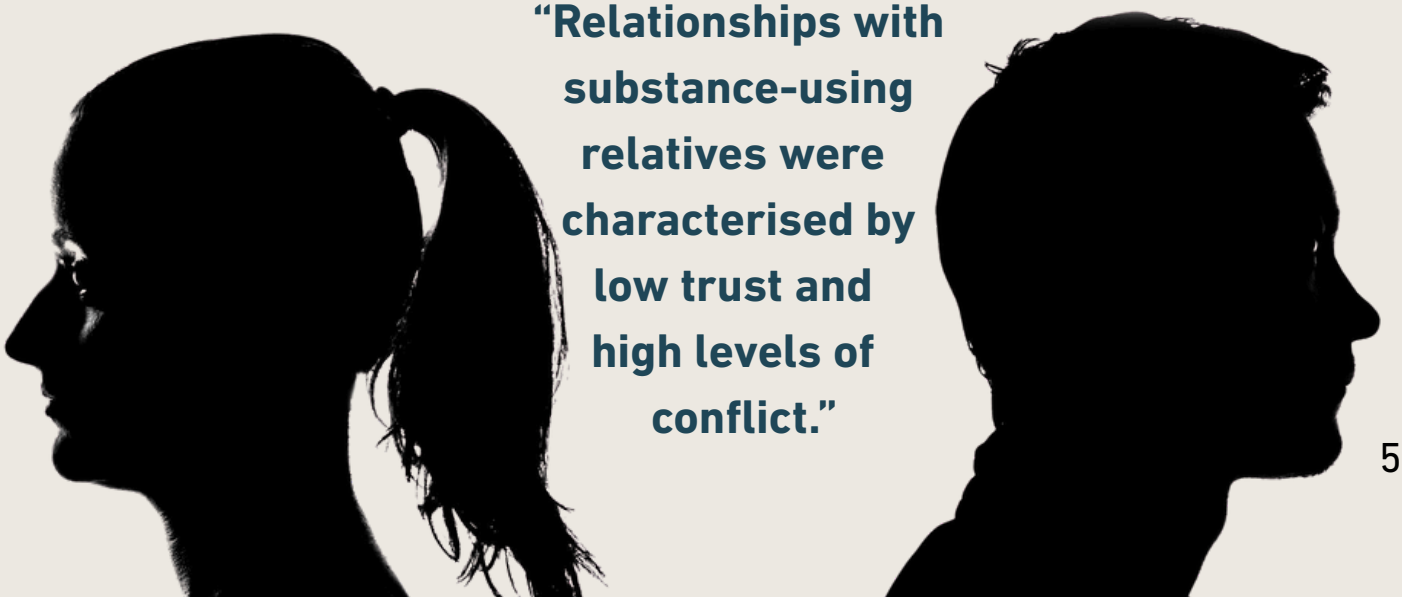


# PROPS Findings

PROPS: Quantitative data collected using the Carer Support Outcomes Profile CSOP) indicated that:

- Carers entered the family support service with moderate knowledge of substance use effects
- Relationships with substance-using relatives were characterised by low trust and high levels of conflict
- Relationships with other family members were considerably stronger, with higher ratings of trust, communication and support
- Carers reported high levels of anxiety, low mood, disrupted sleep and difficulties managing stress
- Carers also had relatively low confidence dealing directly with their relative and reported low engagement with peer support

From the qualitative data, the carers were universally positive about the family support service — one person reporting that "It gave me the confidence and the knowledge to be able to say no, to be able to say I'm not putting up with that anymore." Family support offered information about substance use and helped cultivate carers' ability to make informed decisions and establish healthy boundaries. Involvement with PROPS also generated a sense of belonging and peer support, as exemplified by "I feel like I belong here, and that's not something I've felt for years". This was reflected in the impact on the family dynamic — "We could all talk more easily with each other".



**"Relationships with substance-using relatives were characterised by low trust and high levels of conflict."**

# PROPS Findings (continued...)

The support derived from peer group involvement was seen to strengthen carers' own wellbeing and had a ripple effect on the family holistically, improving communication, trust, and cohesion. There was also the benefits of learning how to manage the process from the staff at PROPS and from others' experiences, exemplified in the statement that "Even when things go wrong, I know I've got tools and support to keep going."

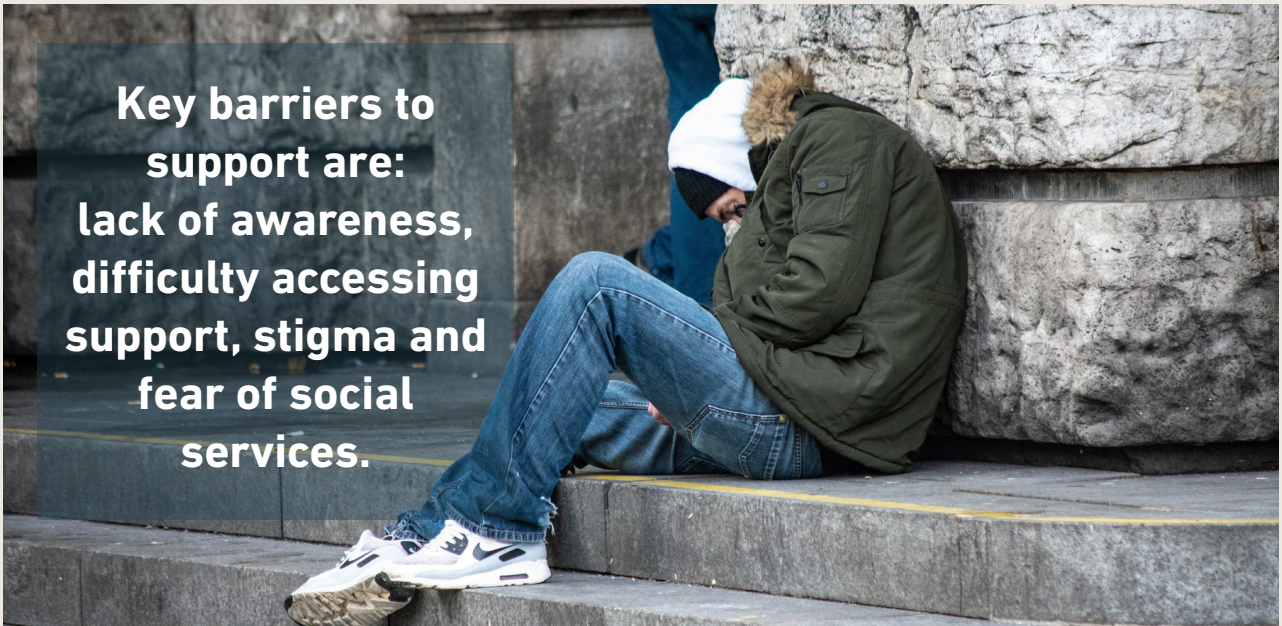
This was essential as families reported the cumulative effects of stress and burnout — "I was exhausted and I felt like there was nothing I'd go on that I could stop," something that was particularly strongly felt by female caregivers "I was the one who was trying to hold everybody together". The PROPS data demonstrated the benefits of personal and social growth through peer and professional support, and showed that family recovery was a journey over time.



# Recovery Connections Findings

Recovery Connections: Consistent with the Adfam data, family members of Recovery Connections services only rarely accessed support for themselves. The survey and focus groups were able to explore the reasons for this. Key barriers to support included lack of awareness (70.6% participants, 57.1% family members), difficulty accessing support (58.8% and 42.9%), stigma (58.8% and 42.9%), and fear of social services involvement (47% and 28.6%). More than half (53.5%) reported actively avoiding support due to fear of social services involvement, mainly over fear of losing children, being judged, or lack of understanding from professionals. One participant reported that "Women are scared to ask for help because then, boom, they're coming to take your children away".

Even where there was awareness (and perceived need), engagement was low. 53.3% were aware of parenting classes and over half identified a need, but only 18.2% had attended. Similar gaps were observed for family therapy, SMART Family and Friends support, and family mediation. People in recovery saw education and awareness for family members as essential to address some of these gaps, as indicated by one participant who said "Families don't understand addiction — it's not just about stopping; it's a disease". Gender- and child-specific supports were particularly important, including childcare provision, women-only meetings, and preventative parenting interventions: "You're educating the parent on a parenting course...when it's too fucking late basically"



# Developing a Family Recovery Capital Framework

**Five key themes** were identified through the synthesis process that brought together the three datasets.

## 1. Relational Trust, Communication and Asynchronous Recovery

Families across all three datasets described strained or fractured relationships, characterised by low trust and poor communication, particularly in the early stages of recovery. There is also asynchronous recovery, where family healing typically progresses more slowly than individual recovery.

## 2. Emotional Strain, Burnout and Gendered Caregiving Burdens

A consistent theme was the emotional toll of caregiving, often marked by exhaustion, stress and invisibility, particularly for female caregivers.

## 3. Knowledge and Skills Gaps in Families

Families identified limited understanding of addiction and recovery as a barrier.

## 4. Belonging, Reciprocity and Ripple Effects

Positive recovery experiences were consistently characterised by belonging, reciprocity, and ripple effects across families, where family recovery capital both sustains and multiplies through shared growth.

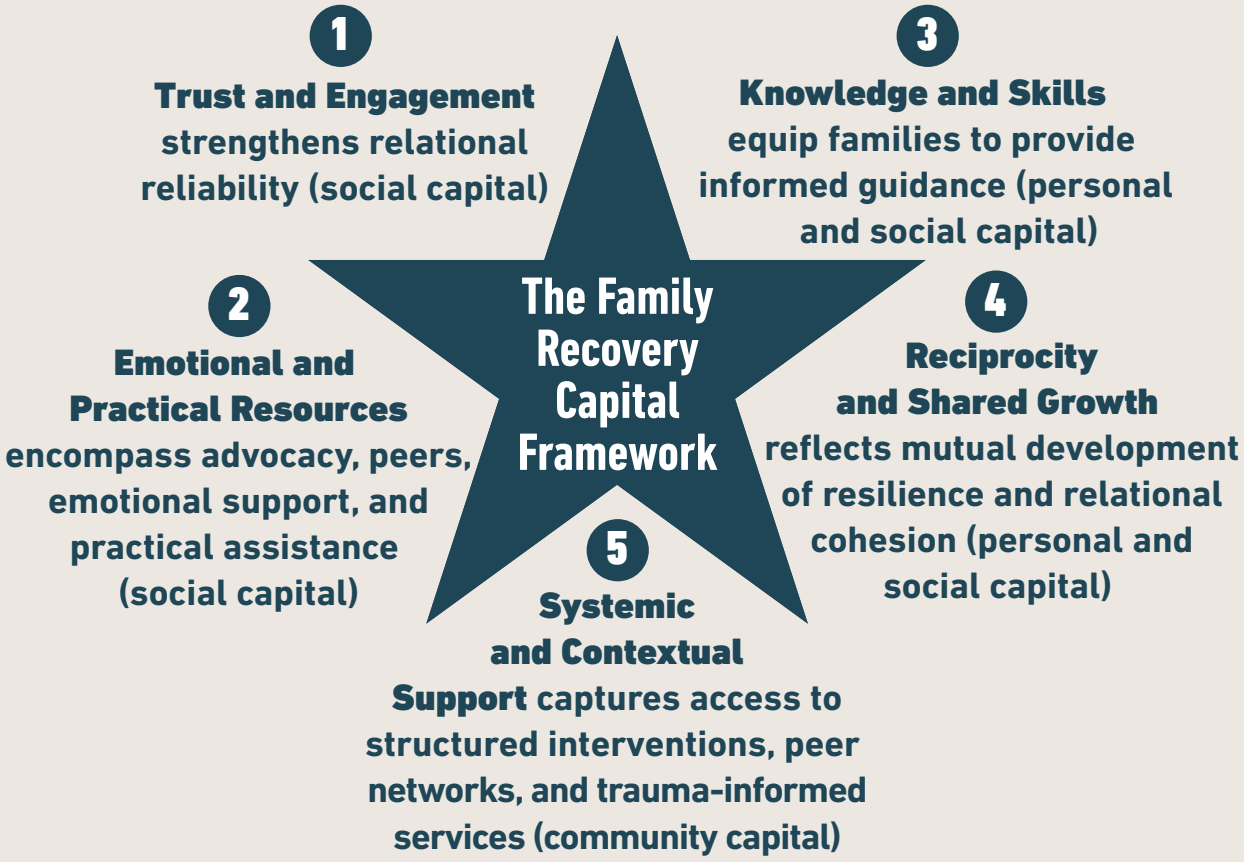
## 5. Systemic Barriers and Service Gaps

Finally, all three datasets highlighted systemic barriers to effective family support, including lack of resourcing for family services, limited availability of family interventions, stigma, fear of child removal and inconsistent service provision.

# Developing a Family Recovery Capital Framework

From these themes we have developed the Family Recovery Capital Framework (FRCF) in which families accumulate resources, which reinforce the recovery process. In early stages, family involvement is often limited, cautious, or inconsistent, particularly when relationships have been strained by substance use, conflict, or trauma. Over time families with adequate support can contribute positively to recovery and can undertake their own journeys of recovery.

The FRCF identifies five domains of family recovery capital, which map onto traditional recovery capital constructs.




While these domains can be mapped against the standard recovery capital domains of personal, social and community capital, we will start the process of developing measurement methods for these five domains. This will be based on the assumption that (as outlined in Cloud and Granfield, 2008) there will be negative and positive dimensions to each of these domains. In spite of this, the overall goal is not only to have a mapping process that accurately captures family recovery capital, but pathways to interventions in each domain that can strengthen each area of family recovery capital.

# Next steps and implications

Our first aim is to disseminate these findings and generate support and consensus for this work. We will then look to develop metrics and measures for family recovery capital that can provide a systematic and scientific basis for linking families to particular kinds of interventions and supports. The partners will continue to work together to raise awareness of family recovery needs and issues and to develop a model for integrating and testing recovery pathways for families in the UK and internationally.

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# The Future of Recovery Research[1]

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**17th International Congress on Addiction Science**
**February 11, 2025**

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 and why I think the work of Congress 60 is so important within those contributions.

## 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--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.

Internationally, there are now increased calls to extend the center of the addictions field from pathology and brief intervention paradigms to a resilience and recovery paradigm. This shift is particularly important to the future of medication-assisted treatment and post-treatment recovery support.

## 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 attention.

**1 Definition and Measurement of Recovery** Recent controversies over a 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. Recovery definitions and

[1] Adapted from: White, W. (2024). Frontiers of recover research (opening keynote). National Conference on Recovery Research Science, The Consortium on Addiction Recovery Science, April 24-25, 2024.

measures that serve our research agenda must move beyond vague, aspirational language to achieve the clarity and precision that its import demands. In the context of medications for the treatment of Opioid Use Disorder (MOUD), that will require consensus definitions on such terms as remission, recovery, abstinence, adherence, retention, and recurrence/relapse. Remission involves the elimination or reduction of pathology below the diagnostic threshold, while recovery conveys achievement of remission plus enhancement of global health, social functioning, and the potential to flourish.

**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 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. In particular, we need findings on the medicinal agents most support of brain repair within the stages of opioid use disorder remission and recovery.

**3 Incidence and Prevalence of Opioid Use Disorder (OUD) and 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 remission and 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 OUD recovery is and is not flourishing. We need to know if remission and recovery are increasing or decreasing and what populations are and are not achieving recovery.

**4 Resolution and Recovery across the Severity Spectrum** Drug-related 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 potential of 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.

**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 and 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. These are the kinds of critical questions that lie unanswered within the existing body of addiction-related science. 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.

**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"—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.

**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** A growing number of addiction professionals are advocating the extension of acute care models of addiction treatment to models of sustained recovery management. 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 lie in finding multiple interventions that when uniquely combined or sequenced generate dramatically amplified recovery effects.

**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, collegiate recovery programs, recovery-focused employment programs, faith-based recovery support programs, 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. Collectively, these represent efforts to expand *community spaces/landscapes in which recovery is welcomed, supported, and celebrated*. There is a growing 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.

**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 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 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. 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, 2) the authenticity of recovery representation, and 3) the diversity of recovery representation.

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.

**Congress 60**

Before closing, I would like to offer an international perspective on why I think the work of Congress 60 is so important to the future of recovery research. I base these comments on my regular communications and collaborations with Congress 60 since first meeting Mr. Hossein Dezhakam in 2009. Historically, the professional treatment of OUD has utilized two competing approaches: 1) psychopharmacological treatment, and 2) psychosocial treatment, with each nested within an isolated system of care whose proponents claim moral, clinical, and scientific superiority. While MOUD is designated the “gold standard” for the treatment of OUD, its value is limited by low attraction, weak engagement, high rates of medication adherence and discontinuation, and post-treatment OUD recurrence and related morbidity and mortality risks—many risks also shared with psychosocial treatment approaches. I know of no program internationally other than Congress 60 that has more fully and effectively integrated medication support and psychosocial support to overcome these limitations. In that process, it offers a distinct view of the etiology of addiction (X theory), a distinctive medical agent (opium tincture), a novel scheme of extended but time-limited medication support (DST method), the framing of smoking cessation as a crucial element of full recovery, intensive psychosocial support including intense and prolonged family engagement, an

elaborate system of peer recovery support services (the use of Guides and Co-Guides), all wrapped in a vibrant culture of recovery that involves members in sports, music, the arts, and community service as part of their identity and lifestyle reconstruction. Congress 60 also stands as a model of an NGO pursing addiction-related research in collaboration with external research scientists as a means of continually advancing its treatment technology. These are among the reasons I have continued to collaborate with Congress 60 for the past sixteen years. It is my view that many of its innovations warrant continued scientific study and widespread replication and adaptation internationally.

**Closing**

In closing, let me say that a now passed and aging generation of recovery advocates and visionary addiction professionals 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, we leave the future of that vision in your hands. Thank you again for the honor of being with you today.

**Citation**: White, W. L. and Kelly, J. F. (2025) Toward a solution-focused addiction science. *Frontiers in Public Health,* 13:1701524. doi: 10.3389/fpubh.2025.1701524

## Abstract

During the past 50 years there has been immense progress in our understanding of the etiology, pharmacology, neurobiology, epidemiology, and typologies of alcohol and other drug use disorders that has given rise to numerous novel pharmacological and behavioral treatments and recovery support services. Consequently, much has been documented and published regarding the causes and effects of drug use, addiction, related pathologies, and myriad modes of treatment. While such progress is to be celebrated, significant challenges nevertheless remain. This paper describes a novel perspective that proposes to enhance the effectiveness of our international efforts in addressing endemic drug problems through rigorous investigation into the successful long-term solutions that exist within the lived experiences of individuals, families, and communities. In this regard, such solutions are proposed to exist on a continuum of change spanning five domains: *resistance*, *resilience*, *risk minimization*, *remission*, and *recovery,* with each viewed as an independent achievement or as stages within a larger process of personal change. Ultimately, it is argued that the frontiers of addiction research lie in extending our study of the problem to include an intense focus on the prevalence, pathways, processes, styles, and stages inherent within these five domains.

Sondhi, A. Best, D., Leidi, A., Belanger, M., Bunaciu, A. & White, W. (2026). The impact of medications for opioid use disorder (MOUD) on retention and recovery capital in recovery housing: An exploratory causal inference analysis. *International Journal of Drug Policy*, 151, 105218.

## A B S T R A C T

*Background:* Medications for Opioid Use Disorder (MOUD), including methadone (MET), sublingual buprenorphine (SL-BPN), extended-release buprenorphine (ER-BPN), and naltrexone (NTX), are increasingly used in recovery housing settings. However, their differential impact on retention and recovery capital remains underexplored.

*Methods:* We applied marginal structural models to explore the causal effects of MOUD on retention and recovery capital among individuals with substance use disorders in Virginia Recovery Residences (January 2020–May 2024). Model 1 compared MOUD-exposed ($n$ = 509) and non-exposed individuals ($n$ = 8785). Model 2 examined effects by medication type. Models 3 and 4 analyzed longitudinal changes in recovery capital using data from 5333 clients and 23,325 assessments. Marginal models for repeated measures estimated mean changes in recovery capital scores from baseline.

*Findings:* MOUD exposure was associated with a six-percentage-point increase in predicted retention. Recovery capital improved significantly between 3- and 4.5-months post-entry. NTX showed superior retention outcomes compared with MET and both buprenorphine formulations. SL-BPN and ER-BPN were associated with enhancements in recovery capital within the first three months.

*Conclusion:* Different MOUD agents were associated with distinct patterns in recovery outcomes. NTX was associated with higher predicted retention, while buprenorphine formulations promote early gains in recovery capital. These findings underscore the importance of aligning pharmacological strategies with individual recovery trajectories, particularly during the initial six months of residency. Further longitudinal research is needed to inform treatment-matching approaches based on motivational and clinical profiles.

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ADDICTION OPINION AND DEBATE

ADDICTION SSA

# On the need and contents of a specific addiction recovery research agenda

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## Abstract

**Background:** For decades knowledge about the etiology, epidemiology, neurobiology, typology, and treatment of addiction in various populations has been well documented and widely disseminated. In more recent years, there has been a growing interest in investigating the prevalence, multiple pathways, and mechanisms that facilitate sustained remission and long-term stable *recovery*. Such an endeavor is predicated on the belief that discovery of not just more effective short-term stabilization and addiction treatment protocols, but also how people achieve long-term recovery will help ameliorate current addiction crises. Such experiential knowledge could inspire and inform the testing of new service strategies to meet the dynamic recovery needs of diverse populations—services that could be coordinated with, or supplant, existing ones toward the goals of engaging affected individuals and families earlier and better supporting them across the long-term stages of recovery.

**Argument/Analysis:** The "why", "what" and "how", involved in creating and pursuing a recovery research agenda is described, with detailed attention given to twelve significant research dimensions that promise to enhance understanding of the multiple recovery pathways and mechanisms and thereby improve the precision, nature, timing, and scope of services. The article also describes how best to engage with recovery communities cross-culturally to obtain the most accurate, informative, and beneficial results.

**Conclusions:** A new science of addiction recovery promises to reinvigorate and vitally inform clinical and public health efforts in ameliorating endemic harms related to addiction.

KEYWORDS
addiction, agenda, problem resolution, recovery, remission, substance use disorder

## INTRODUCTION

For decades, knowledge about the etiology, epidemiology, neurobiology, typology and treatment pertaining to and addressing alcohol and other drug (AOD) disorders in various populations around the world has been well documented and disseminated [1–6]. In more recent years, there has been a growing interest and trend to investigate the prevalence and the multiple pathways and mechanisms that facilitate and help explain sustained remission and long-term stable AOD disorder recovery [7–10, 11]. Such endeavor is grounded in the belief that understanding not only effective short-term stabilization and treatment protocols for AOD disorders, but also how people achieve long-term stable recovery, will inspire and inform new services that can meet the dynamic recovery needs of diverse populations—services that could be aligned and coordinated with, or supplant, existing ones working toward the goals of engaging affected individuals and families earlier and supporting them across the stages of long-term recovery [12–14]. In this article, we describe the 'why' (the rationale for recovery research), the 'what' (the specific aspects that need to be researched) and the 'how' (the ethical procedures for conducting such research), in arguing for an expanded recovery research agenda. It is hoped that this agenda may help national governments

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and international agencies formulate research targets and priorities across broad biopsychosocial public health and health service domains.

## 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 AOD arena: (i) experiential knowledge; (ii) public and cultural perceptions; (iii) professional/clinical knowledge; and (iv) scientific knowledge. Extensive studies have been published on addiction and its related pathologies and brief clinical interventions [6, 15, 16], but until recently, only a paucity of material existed from the standpoint of science about the prevalence, pathways, processes, styles and stages of long-term personal and family recovery across the continuum of care, beyond initial stabilization and brief treatment.

At the turn of the 21st century, people in recovery and their allies launched a new recovery advocacy movement [14, 17, 18]. They proposed shifting the center of the AOD 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 [19]. They argued that recovery is as dependent on previously dormant internal and external assets as it is 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 [20]. They lamented that some of the most critical questions related to long-term recovery had yet to be addressed by the research community and advocated in support of an expanded recovery research agenda.

We believe there is legitimacy and import to such requests. The shift to a recovery paradigm, and within that shift the pursuit of a recovery research agenda, is filled with hazards and opportunities. Such a shift requires deep exploration of some of the most contentious issues within the field, with outcomes profoundly affecting individuals, families, organizations and communities [6, 7, 21, 22, 23].

## WHAT

The second foundational issue involves the most critical questions that we believe need to be addressed within national recovery research agendas. We briefly note 12 critical dimensions of recovery that warrant focused attention to varying degrees.

### Definition and measurement of recovery

Creating an encompassing definition of recovery has garnered much attention and discussion in the past 20 years. Some of the most popular definitions are listed below along with their different key elements (Table 1). No science of addiction recovery is possible without a working definition that meets the criteria of precision, inclusiveness, exclusiveness, measurability, acceptability and simplicity [14]. 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 extend 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, precision and operationalization that its import demands.

As noted by Kelly and Stauffer [31], there are subjective and more standardized, objective, ways of measuring 'recovery', with several studies now documenting subjective self-defined recovery status and prevalence rates, but only one that we know of that has examined specific recovery prevalence and utility using an objective operational definition [26, 31]. We realize that creating a measurable operationalized recovery definition is not easy in a multi-dimensional construct like recovery, where measurement thresholds (e.g. what level of any specific recovery subdimension must a person achieve before it is considered to have prognostic significance) and durations (e.g. for how long must that element endure at that threshold for it to be considered to have prognostic utility) must occur to be able to inform answers to the kinds of serious questions noted above (e.g. whether someone should be denied child custody or not) [31]. Several very well-conceived and constructed measures of recovery-related change exist, but while useful in their own right, these are mostly dimensional process measures of improvements in psychosocial status and functioning [32–34], and cannot yield standardized, objective, recovery prevalence rate data or provide thresholds for deciding important socio-legal decisions (e.g. child custody), such as can be done with objective criteria for diagnostic remission. Operationalized definitions are emerging [26], and are shown to have potential clinical and public health utility [31], but there remains a tension between measurable operationalized definitions, which typically require narrower and more concrete elements involving thresholds and durations, as noted above [26], and the often broader descriptive conceptualizations of 'recovery' as including multiple indices of functioning, emotional growth and psychological wellbeing. We argue that we need more tests of the former (operational and testable definitions) and not of the latter (descriptive definitions) [25].

### Neurobiology of long-term recovery

Tremendous progress has been made in recent decades in unraveling the neurobiology of addiction [6, 35], while far less attention has been devoted to unraveling and disseminating information on the neurobiology of short- and long-term addiction recovery [7]. People seeking and in recovery, and their caregivers, need normative data on the degree and stages of neurobiological repair following recovery

**TABLE 1** Some common addiction recovery definitions.

| Source/organization | Recovery definition | Key elements/themes |
|---|---|---|
| American Society of Addiction Medicine (ASAM) [24] | The ASAM defines recovery as an active and ongoing process of sustained action that addresses the biological, psychological, social and spiritual disturbances associated with addiction. It is a path to improved quality of life through a consistent pursuit of abstinence, improved behavioral control, relief from symptoms and enriched relationships | Focuses on the broad multifaceted and dynamic nature of recovery |
| Betty Ford Institute Consensus Panel [25] | A voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship | Focus on sobriety, personal health and citizenship as defining features |
| National Institute on Alcohol Abuse and Alcoholism (NIAAA) [26] | Remission plus cessation from heavy drinking | Focus on diagnostic remission and no more then low-level alcohol exposure that does not exceed NIAAA-defined guidelines for low-risk use |
| National Institute on Drug Abuse (NIDA) | Recovery from drug addiction means a person stops using drugs and starts to lead a healthy, productive life | Abstinence, health, functioning |
| Recovery Science Research Collaborative [27] | Recovery is a dynamic process involving sustained improvements in biopsychosocial functioning and wellbeing, which may or may not include abstinence, and which involves growth, connection and purpose | Dynamic process, wellbeing, connection, growth, abstinence-optional |
| Substance Abuse and Mental Health Services Administration (SAMHSA) [28] | A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential | Emphasizes process, health, self-direction, purpose and community participation |
| UK Drug Policy Commission (UKDPC) [29] | The process of recovery from problem drug use is characterized by voluntarily sustained control over substance use, maximization of health and wellbeing, and participation in the rights, roles and responsibilities of society | Emphasizes personal control over substance use, health and wellbeing, and social reintegration |
| White & Kurtz [30] | The experience (i) through which formerly dependent persons resolve alcohol and other drug problems, (ii) heal the wounds inflicted by active addiction and (iii) actively manage their continued vulnerability to relapse, while rebuilding meaningful and productive lives | Healing, ongoing management, meaning and productivity |

initiation, and caregivers need science-informed guidelines on how to best provide specific recovery support that can aid or even accelerate healing. 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. Similarly, there is a need to better align pre-clinical animal research with emerging neuroscience on resilience so that such models can inform and confer greater benefit to understanding recovery. Broader biobehavioral assessment that includes neurobiological findings coupled with measures of psychosocial functioning will also help to uncover the robustness of brain–behavior links; whether and how, for example, potential recovery-related gains in functioning may be possible even when observable neurobiological deficits persist, and vice versa.

## Incidence and prevalence of recovery

Governments often meticulously measure year-to-year trends in the incidence and prevalence of AOD use and the toll of addiction via death, disease, and multiple social and economic cost categories [16,

36] but, until recently [10, 16], have not assessed parallel trends on the incidence and prevalence of recovery. Recent recovery prevalence [8, 37 ] and life in recovery surveys [10, 38–42, 43] are challenging many prevailing myths about addiction recovery—at least subjective, self-defined, recovery, as noted above. Though this has begun in countries such as the USA [16] and the UK [40], further international efforts are needed to integrate recovery-specific and related questions into existing population-based substance use and broader public health surveys. Targeted interventions may not be possible unless we are able to regularly measure with whom and where recovery is and is not flourishing. Recovery prevalence in and of itself may well constitute a valuable form of community recovery capital, as a greater number of observable successfully recovering role models across societal strata may be able to help reduce stigma and attract and engage others into the recovery process; we need to know if such community recovery capital is increasing or decreasing and which subpopulations are and are not achieving sustainable recovery. As noted above, however, if we are to move beyond estimating rates of subjectively defined 'recovery', consensus will need to be reached on standardized objective criteria specific to addiction recovery [31].

## Resolution and recovery across the severity spectrum

Alcohol and other drug (AOD) 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 such problems in clinical populations generally portray such problems as severe, self-accelerating and resolved primarily through involvement in specialized addiction treatment, post-treatment recovery mutual aid participation and lifelong AOD abstinence. Studies of AOD problems in community populations conclude that most such problems are mild to moderate, transitory and are resolved without specialized professional care or formal peer recovery support. Such transitory problems are most often resolved via maturation, change in life circumstances, improved coping skills and the deceleration rather than complete cessation of drug use [8, 40, 44, 45]. 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. Research is needed to understand which specific phenotypes of substance involvement and impairment might be more likely to follow which type of trajectory and achieve and maintain which outcomes.

## Pathways and styles of recovery across diverse geographical/cultural/religious contexts and clinical subpopulations

There is much to be learned about the many potential recovery-related changes and outcomes that can occur across the multitude of subgroups that meet the lifetime criteria for an AOD disorder. These can take the form of sudden transformative change, versus incremental change, or partial, full and amplified recovery, where individuals not only survive but thrive way beyond pre-morbid functioning levels [30]. Recovery pathways can be secular, spiritual or religious [46], with and without embracing a recovery identity [47, 48]. Recovery can occur with and without participation in recovery mutual aid fellowships, and with and without specialized addiction treatment, including the use of medications. Recovery can involve single or multiple pathways ('dual citizenship' in recovery) and there can be pathway transitions over time. There is the potential of pathways to unwittingly inflict harm in the name of help. Such work 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 [30].

Exploring the varieties of addiction recovery experience 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 [46, 49, 50, 51], but the prevalence and variability of such pathways within these communities remains unclear. 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 [10, 52], 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.

## Recovery across the life course

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 [45, 53]. This resulting knowledge base has until recently excluded two critical groups at the ends of the age distribution of affected persons: (i) adolescents and transition-age youth; and (ii) older adults. How is recovery different when it is initiated at age 17 years rather than at age 35 or 45 years? What role do youth-specific recovery support services such as recovery schools and recovery supports in college settings play [54, 55]. What special obstacles and opportunities exist when recovery is initiated early or late in one's life [56]. 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 [45, 57, 58, 59], 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 the 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 [60].

## Stages of recovery

Let us for a moment posit five potential stages of addiction recovery: (i) pre-recovery, a period of recovery incubation/priming; (ii) recovery initiation and stabilization; (iii) transition to long-term recovery maintenance; (iv) enhanced quality of global health and social functioning in long-term recovery; and (v) 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 the needs of individuals and families evolve across these stages [43], 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. Furthermore, the different needs of individuals that may arise at different recovery stages may themselves intersect with a multitude of other variables, including the age at which recovery is initiated (e.g., during adolescence/emerging adulthood vs older adulthood) or sex and gender, which bring with them different life-stage and life-context challenges.

## Social transmission of recovery

One of the central discoveries of the recovery advocacy movement is imbedded within the slogan that 'recovery is contagious', meaning that recovery may be socially 'transmitted' and may 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 life and character [61]. As noted above in relation to recovery prevalence being a potential form of community recovery capital, such processes of recovery transmission require disentanglement and testing as to whether recovery prevalence could be significantly increased by elevating the density and visibility of recovery role models within a social network or local community. This potential also calls for research into potential recovery cascades—sudden and dramatic surges in recovery initiation—and the factors that might incubate, lead to and sustain such cascades. The key question is whether it is possible to strategically shorten the course of substance use disorders and extend the durations of recovery, amplifying years of recovery achievements and reducing the cumulative toll of addiction-related harm to individuals, families and communities.

## Family recovery

The many hundreds of millions of family members affected by addiction globally has been described as 'a major but neglected contributor to the global burden of adult ill-health' [62]. Highlighting the gaps in recovery-specific, as well as other, research on family functioning patterns, help for family members and family addiction impacts globally, Bischoff and colleagues [12] summarize and document the substantial evidence base on the experiences, harms and patterns of support among affected family members, but note that the field overall remains under-researched, under-recognized in policy and under-supported in practice. Their extensive work highlights the fact that the hundreds of millions of affected family members worldwide suffer high levels of stress, poorer mental and physical health, stigma, financial burden and social isolation, yet receive vastly inadequate support from health and social systems. They argue for a multi-layered response encompassing policy changes, practice shifts and research priorities. On the policy side, affected family members need formal recognition within addiction strategy frameworks so they are not relegated to 'secondary' or invisible status. In practice, health and social care workers should receive training to sensitively identify and respond to family members, and services should integrate family-oriented support rather than focus solely on the person with the addiction. Clinically, this means expanding evidence-based interventions that address the trauma, coping needs and long-term wellbeing of family members in their own rights, rather than merely as adjuncts to the addicted person's treatment. For research, more rigorous and long-term, culturally and contextually diverse studies are needed that include and incorporate the affected family members' voices, examine outcomes from the perspective of families (not just 'identified patients') and test interventions tailored to different subgroups (e.g. male partners, low-resource settings). Increasing the visibility and voice of family is deemed essential to mobilize resources and develop meaningful, equitable support systems [12].

McCrady and Flanagan [63] also highlight the fact that while much has been learned about how the family is impacted by addiction and how it may need to, and does, re-adjust and adapt during the early stages of recovery, further studies are needed that can inform the family recovery process and that can guide caregivers in the design and construction of the most effective family support scaffolding that may be needed for different individuals at different stages of recovery and stages of life within and across cultures. For instance, adult parents may well have different tasks and face distinct challenges for adolescent/emerging adult offspring starting recovery than partners or spouses or parents [64].

The importance of family-specific recovery research was highlighted long ago in work conducted by Stephanie Brown and Virginia Lewis [65], in one of the first in-depth studies on the effects of addiction recovery on the family, which drew an unexpected conclusion. They found that recovery initiation could *destabilize* families whose relationships, roles, rules and rituals had for years of active addiction been frozen into self-protective but toxic patterns. 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—points echoed and amplified by Bishchof and colleagues [12].

Finally, considerable attention has also been given to the intergenerational transmission of AOD problems [66], but far less attention

to mechanisms that may be used to break such cycles and promote intergenerational resistance, resilience and recovery.

## Recovery management and recovery-oriented systems of care

In the closing years of the 20th 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 sustainable recovery [14, 67]. 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 (ROSCs) [68, 69], with 'systems' defined not as the treatment system but as the larger mobilization of recovery support resources within the community. At the federal level in the USA, 'Access to Recovery' (ATR) created structured 'service menus' consisting of curated lists of clinical and non-clinical services from which individuals could choose based on their recovery goals and preferences. These service menus were built collaboratively with community stakeholders and people with lived experience, and included supports such as recovery coaching, peer support services, housing assistance, employment counseling, relapse prevention, transportation, case management, education and support groups. The menus were intended to expand the continuum of care and formally legitimize recovery supports that had traditionally been under-funded and considered ancillary to clinical treatment [31, 70]. Such ROSC models also often involved assertive outreach and early intervention, 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 [71], and, if and when needed, early reintervention [71, 72]. 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 [31, 67].

As research scientists, we isolate and evaluate the effects of narrowly defined interventions, but the greatest breakthroughs in enhancing future recovery outcomes may well lie not within a single new personal or environmental intervention, but in finding multiple interventions that when uniquely combined or sequenced generate dramatically amplified recovery effects. What might 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. Thus, in addition to the development and testing of new multifaceted programs, research is needed that examines the utility of self-selected 'treatment and recovery support menus', the clinical and non-clinical recovery support services of which can be personally combined and strategically sequenced across the stages of personal and family recovery.

## New recovery support institutions, service roles and recovery cultural production

For more than 150 years, recovery mutual aid societies and professionally directed addiction treatment programs have coexisted as the two specialized groups 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 [73]. These new institutions include recovery advocacy organizations, recovery community centers [31], recovery residences [74], recovery high schools and collegiate recovery programs [54], recovery-focused employment programs, recovery ministries, recovery cafes, and recovery-focused sports and leisure activities [41]. Newly conceived peer recovery coaches and recovery support specialists are serving in a wide variety of contexts [75, 76]. And people in recovery are expressing and celebrating their recoveries through the vehicle of recovery cultural production in the arenas of history, 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 [27, 77]. 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 [78]. Also, as in evidence-based addiction treatment services implementation research [79], the same types of implementation science frameworks and best practices must be researched and applied to the optimal uptake and effective delivery of these newer recovery support institutions and services.

## Flourishing/thriving in recovery

Traditionally, addiction recovery has been viewed as a process of subtraction—deleting or decreasing 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) [80, 81]. 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 that addiction inflicts on individuals, families and communities, but, until recently, little if anything has been revealed about the assets that recovery returns to individuals, families and communities [82].

## HOW

The third foundational question involves the processes through which recovery research should be designed, conducted and disseminated. Put plainly, most of the design and implementation of published studies on addiction recovery have not been directly informed by people in recovery, and nor have the fruits of such research reached the people in greatest need of science-grounded information on recovery in different regions and countries. In this regard, all recovery research efforts could benefit from earlier work on cross-cultural research and the risk of cultural appropriation [83]. 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: (i) the need for recovery representation; and (ii) the potential for recovery research; with the latter reflecting more comprehensive and in-depth involvement by individuals with lived experience of addiction and recovery in the design, implementation, documentation, summarization, and publication of addiction recovery science [6, 84, 85].

Assuring recovery representation within recovery research addresses three concerns: (i) the adequacy of recovery representation (beyond token inclusion); (ii) the authenticity of recovery representation (avoiding the problem of 'double agentry'—masking of hidden personal/institutional interests behind the claim of recovery status); and (iii) diversity of recovery representation (demographic, cultural and recovery pathway diversity).

As noted in the mental health field more broadly in describing the principles and practices of community-based participatory research [86, 87], recovery research co-production needs to involve more of a state of co-ownership in which people in recovery participate with other research team members on an equal co-production footing. This means 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. This also means recruiting and supporting researchers with lived experience of addiction into PhD programs, postdoctoral fellowships and recovery-oriented research training environments [84].

The goals of recovery representation and co-production also go beyond enhancing study quality to first adhering to the ultimate ethical guideline of 'First do no harm'—in this case, to recovering individuals and families and their associated social institutions. Recovery representation and co-production will also help assure study utility. It is not enough to publish recovery research findings in access-restricted scientific journals via articles couched in the equally inaccessible arcane language of science. What is needed is not just the conduct of recovery research, but its translation to enable 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.

Co-production involves the 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.

## CONCLUSION

Whereas much has been learned during the past 50 years about the causes, consequences, clinical course and ingredients necessary to facilitate short-term stabilization in the care of addiction, comparatively little is known about the factors associated with producing initial and sustained remission and facilitating stable long-term recovery [13, 18]. There are estimated to be tens of millions living such recovery every day around the world [8, 10, 40], yet such populations have largely remained an untapped source of knowledge [8, 14, 88]. There have been recent government initiatives to grow the science base, particularly regarding the clinical and public health utility of a variety of mostly peer-based recovery support services for different populations in the USA (e.g. the National Institute of Drug Abuse Recovery Research Networks initiative), but much remains to be learned about the dynamic developmental recovery-specific needs of different people seeking and following the many different pathways of recovery. Here we have outlined a potential research agenda based upon our collective decades of focused attention and scientific review in these areas that may be useful in stimulating and amplifying research.

Perhaps, most pivotally, if we are to move beyond descriptive 'recovery' definitions and prevalence estimates, based on purely subjective self-defined definitions (although these are also useful), to estimating standardized, objective, recovery-specific prevalence rates that are distinct from diagnostic remission rates, and enhance the value of 'recovery' as something separate and useful in its own right [31], then we need to develop testable operational definitions [26, 31]. We also believe that there is much to be gained from a broader, dynamic and developmental, biopsychosocial model that explicates the complex interplay of intra- and extra-individual contextual factors across multiple recovery pathways over time—but a model that once again moves beyond purely diagnostic remission [31, 78]. In the spirit of ethics and fairness, we also advocate for a greater active incorporation of the voices of lived experience—and the personal expertise that comes with it—of those individuals and family members who have suffered first-hand from the effects of addiction in recovery research design, measurement and execution. Such experiences are likely to

enhance the efficiency and precision of research efforts and thus also the ultimate yield from research investment. In turn, these populations who contribute, and stand to benefit from the new information gained, should be the most immediate beneficiaries of any expanded knowledge, disseminated to them in ways that they can understand and use. Enhanced knowledge in these areas has the potential to further shift the clinical and public health addiction paradigm from one involving mostly brief, discrete, episodic, clinic-based, interventions, to one that involves building a broader, more cost-effective and more finely-tuned public health infrastructure involving interwoven clinical and community services informed by lived experience [13].

## AUTHOR CONTRIBUTIONS

**William White:** Conceptualization (lead); writing—original draft (lead); formal analysis (lead); methodology (lead); writing—review and editing (equal); **John Kelly:** writing—review and editing (lead); conceptualization (supporting); writing—original draft (supporting).

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## DECLARATION OF INTERESTS

None.

## DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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# Post Traumatic Growth and Flourishing in Addiction Recovery: A Critical Review and Commentary


## William L. White, M.A.



**A Chestnut Health Systems / Lighthouse Institute and Recovery Research Institute Monograph**







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# Post Traumatic Growth and Flourishing in Addiction Recovery: A Critical Review and Commentary

**William L. White, M.A.**

*ABSTRACT*

The potential for post traumatic growth and flourishing within the experience of addiction recovery has important implications for affected individuals and families, providers of addiction treatment and recovery support services, local communities, and drug policymakers. The author conducted a review of relevant literature and explored his decades of experience interviewing, surveying, and observing individuals in recovery to identify potential principles and practices related to recovery flourishing. The review explores the definition and measurement of recovery flourishing, relevant research to date, the interaction between flourishing and substance use status, flourishing domains and dimensions, flourishing in response to existential crisis or as an act of rebellion, temporal influences on recovery flourishing, the role of family and community in recovery flourishing, and service design and delivery implications. The exploration of human flourishing is a key element within an emerging recovery research agenda and tandem efforts to elevate the quality of addiction treatment and recovery support services.

**Key Words:** Addiction recovery, post traumatic growth, flourishing, quality of life, wellbeing

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## Author's Preface

In 2006, Dr. Ernest Kurtz and I published a paper entitled "The Varieties of Recovery Experience" in the *International Journal of Self Help and Self Care* in which we first described an amplified state of recovery—a "better than well" experience marked by exemplary global health, personal functioning, and social contribution.[1] In the years that followed, I briefly referenced this potential within various publications but yearned to explore this potential in greater depth. As I approach my final contributions to the field, this singular topic remained as unfinished business. What follows is a series of investigations, reflections, and unanswered questions on the potential and nature of flourishing within the prolonged experience of addiction recovery.

This monograph is the ninth monograph in a series focused on recovery management of recovery-oriented systems of care. Those preceding it include:

White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management.* Great Lakes Addiction Technology Transfer Center.

Flaherty, M. (2006). *A unified vision for the prevention and management of substance use disorders building resiliency, wellness and recovery* (A shift from acute care to a sustained care recovery management model). Institute for Research, Education and Training in Addictions (IRETA).

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). Great Lakes Addiction Technology Transfer Center.

White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

White, W. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Great Lakes Addiction Technology Transfer

[1] White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.

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*. 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., Galanter, M., Kolodner, G., Kepner, W. E., Sarapas, C., & Mouton, C. L. (2025). *Medications for opioid use disorder: Enhancing retention to achieve long-term remission and recovery*. Chestnut Health Systems, Lighthouse Institute. https://deriu82xba14l.cloudfront.net/file/2461/2025%20MOUD%20Retention%20Monograph%20Final.pdf.

All monographs are available for free download at https://chestnut.org/li/william-white-library/books/books-and-monographs.

For those seeking a cursory review of the subject of recovery flourishing, an Executive Summary highlights some of the key points in the monograph. For those seeking far deeper exploration, more in-depth discussions follow with footnoted references to relevant research. It is my hope that the monograph will stimulate future studies on the phenomenon of flourishing among addiction-affected individuals and families who have found viable pathways of hope and healing.

William L. White

March 2026

## Executive Summary

### Introduction

- Addiction recovery involves processes of subtraction (a foundational state of problem reduction/elimination), addition (enhanced global health and social functioning), and multiplication (growth synergies that produce heightened levels of meaning and social contribution far greater than that which existed prior to the addiction experience).
- Recovery flourishing can be viewed as an experiential process, a state of being, an aspirational goal, a daily practice, or a person-world relationship.
- To spur future research on recovery flourishing, the author conducted a search of flourishing-related research and recorded his observations, hypotheses, and unanswered research questions related to recovery flourishing.

### Why Study Recovery Flourishing?

- Professional and public dissemination of research on recovery flourishing could potentially: 1) lessen the social stigma attached to addiction recovery, 2) shorten addiction careers by motivating early help-seeking and enhancing service retention, 3) promote recovery optimism and raise the low bar of expectations too often placed on people seeking and living in recovery, 4) elevate the status of the addiction treatment and recovery support workforce, 5) expand educational, occupational, leisure, artistic, and community service opportunities for people in recovery, 6) stimulate expanded mechanisms of support across the stages of long-term personal and family recovery, and 7) extol the role of people in recovery as valued and underutilized community assets.

### Recovery Flourishing Definition and Measurement

- Flourishing in the context of addiction recovery is an exceptional level of global (physical/cognitive/emotional/relational/spiritual) health, life meaning and purpose, and social/cultural contribution experienced within the constraints of one's strengths, limitations, and life circumstances.
- Flourishing within the experience of addiction recovery involves getting "better than well", a level of growth that far exceeds the healing of injuries inflicted by drug use.
- There is presently no instrument designed to measure recovery-specific flourishing, though there are instruments that measure broader related constructs as general flourishing, well-being, quality of life, and recovery capital.
- The key challenge confronting research on recovery flourishing is the lack of consensus on precisely what is meant by the term and how its existence and degree can best be measured.

## Addiction, Trauma, Post Traumatic Growth, and Flourishing

- Addiction onset is often preceded by earlier traumas whose effects are further amplified by addiction-related traumas, making traumas both a potential predisposing factor and associated feature of addiction.
- The onset of recovery can also be disruptive for individuals and families given the grief over the lost drug relationship, the severing of drug-related social relationships, the radical reconstruction of identity and lifestyle required of recovery-seeking individuals, and the subsequent radical realignment of roles, rules, rituals and relationships often experienced by recovering families.
- Recovery from addiction, like recovery from other forms of traumatic experience, includes the opportunity for unexpected benefits—a level of growth and flourishing that far exceeds pre-addiction levels of achievement.
- There are multiple patterns of drug problem resolution (resistance, resilience, risk minimization, remission, and recovery, each of which is a potential precursor to post traumatic growth and flourishing.
- International surveys of recovery prevalence and life in recovery and recovery mutual aid membership surveys confirm the potential for substantial achievements in the aftermath of recovery initiation.

## Recovery Flourishing: Research to Date

- The foundational writings of Abraham Maslow, Victor Frankl, Martin Seligman and Mihaly Csikszentmihalyi on post traumatic growth set the stage for increased interest in the potential for flourishing in addiction recovery.
- Studies by McMillen and colleagues, Hart and Sing, and Laudet and colleagues identified growth byproducts of early addiction recovery (increased self-efficacy, enhanced family and social relationships, increased empathy and compassion, spiritual awakening, and development of a new life purpose and priorities.
- Hoorash and Freedman, Ogilvie and Carlson, and Runyan and colleagues were among the first to apply the concept of post traumatic growth to the potential for flourishing within addiction recovery.
- Krentzman and Ogilvie explored the broader application of positive psychology to addiction recovery, and Ogilvie and Hennesy proposed a model of G-CHIME (growth through connectedness, hope, identity, meaning in life, and empowerment) to conceptualize recovery growth and flourishing.
- Positive results were reported in the first studies to evaluate interventions specifically designed to encourage flourishing within the experience of addiction recovery.

## Flourishing within a Spectrum of Wellbeing and Social Functioning

- The potential for flourishing within the experience of addiction recovery is best appreciated within the larger spectrum and gradations of illness and health.
- This continuum can be portrayed as overlapping stages in which one can progress or regress: suffering, languishing, functioning, growing, and flourishing.
- These categories can be applied to the evaluation of functioning within various life domains and contexts. Suffering and flourishing represent the endpoints of a scale of personal well-being, global health, and social functioning.

## Growth, Flourishing and SUD Status

- The relationship among the states of wellbeing, social functioning, and substance use disorder (SUD) status can be a complex one as indicated by: 1) people in active addiction who are able to sustain a pattern of growth or flourishing in at least some areas of their lives for some time in spite of other areas experiencing addiction-related deterioration, 2) people who achieve SUD remission but who continue to languish, and 3) people in SUD recovery who later regress to a state of languishing.
- Flourishing and distress can coexist and progress to stable flourishing; flourishing can regress to a state of languishing or suffering. The boundaries between these states of illness, health and thriving are at present ill-defined but observed to be fluid and amenable to change, sometimes quite quickly.
- It is clear from studies to date that most individuals with lower substance use disorder severity achieve SUD remission without professional intervention, but little is known about the degree of subsequent growth and flourishing related to such remissions.
- Addiction suffering and moderate functioning in early recovery have each been well-documented in the addiction and addiction treatment outcome literature, while the experiences of languishing and flourishing within the long-term addiction recovery process remain under-investigated and a challenge to measure.

## Domains of Recovery Flourishing

- Domains have not yet been established within the experience of recovery flourishing, nor have such domains been tested across a diversity of demographic populations, cultural contexts, and recovery pathways.
- Potential benefits of post traumatic growth and flourishing in addiction recovery span at least five domains: 1) deepened recovery resolve and new priorities flowing from personal survival, new appreciation of life, and

a sense of rebirth, 2) enhanced empathy, tolerance, deepened relationships, and greater emotional expression/connections, 3) enhanced awareness of previously unrecognized personal strengths and limitations, 4) enhanced spirituality, and 5) a new optimistic life path.

- These domains suggest the potential within the recovery process of moving far beyond a fundamental reconstruction of the person-drug relationship to a radical reconstruction of personal character, worldview, values and identity; a reconstruction of family and interpersonal relationships; and reconstruction of the person-community relationship.

**Dimensions of Character in Recovery Flourishing**

- Recovery flourishing domains are closely linked to dimensions of personal character associated with the flourishing experience.
- Trait/experience clusters linked to recovery flourishing span the following:
  --Guiding Vision / Purpose / Passion / Commitment / Sacrifice / Discipline / Persistence / Patience
  --Mastery / Competence / Control / Autonomy
  --Authenticity / Genuineness / Integrity / Honesty / Depth / Presence
  --Release / Energy / Engagement / Absorption / Vitality / Joy / Humor / Creativity
  --Silence / Observation / Listening / Simplicity / Humility / Curiosity / Self-Acceptance
  --Gratitude / Appreciation / Forgiveness (Self and Others) / Tolerance / Openness
  --Spirituality / Serenity / Being “at home” / Sense of the Sacred / Transcendence
  --Harmony / Balance / Inner Tranquility / Integration / Coherence / Wholeness
  --Empathy / Compassion / Kindness / Generosity / Love / Service
- The values implicit within these qualities may differ across cultural settings.

**Recovery Flourishing as the Outcome of Existential/Spiritual Crisis**

- The sense of futility and meaninglessness arising from a Sisyphean pattern of drug use triggers existential despair that can trigger questions whose answers become building blocks of recovery flourishing.
- Where and from whom did I come? Why did I survive when others did not? Who am I and how did I become the person I am today? Was my suffering deserved, undeserved, or both? Am I a victim, volunteer, or villain? Who are “my people”? Where do I feel “at home”? How do I know what is real and true? What do I most cherish? What standards/rules will now guide my relationships with others? What actions/experiences uplift my spirit and imbue a sense of beauty, awe, and wonder? When am I

totally engaged? When do I feel most alive, and what gives me the deepest pleasure and meaning? How can I repay the debts I have incurred? Who do I most admire and want to model myself after? What must I be and do to have a good life? What must I do today to preserve, protect, and extend what I most value? What is the nature of existence and my purpose within it?

**Recovery Flourishing as an Act of Rebellion**

- To suggest that recovery and recovery flourishing can constitute acts of rebellion raises the question, “Precisely what and who is the target of such rebellion?” Styles of rebellion include: 1) recovery flourishing as an act of defiant vengeance and living proof argument in response to doubters and predictors of one’s ultimate self-destruction, 2) recovery initiation and flourishing as a battle against the addiction “monster/beast/dragon”, and 3) recovery and recovery flourishing as acts of resistance against a predatory addiction industrial complex and the larger structures and machinery of oppression of which it is an integral component.
- Rebellion can be fueled by heightened awareness of larger contextual influences on addiction and recovery—breakthroughs of perception about the nature of the world and one’s role in it. More specifically, it is recognition that one has, through one’s addiction, unconsciously participated in one’s own oppression and the oppression of one’s people. It is a commitment to recover as an act of defiance against such oppression.
- Recovery initiation and recovery flourishing as acts of resistance and rebellion within oppressed communities rest on several propositions drawn from the collective experience of Black, indigenous, and people of color (BIPOC) of the world but that are also applicable to other historically exploited and disempowered people (e.g., women, LGBTQ+, migrants, or economically disadvantaged White communities).
- To recover as an act of protest rests on the ideas/strategies of strike, boycott, confrontation, and cultural revolution—a simultaneous withdrawal of self and one’s resources from the addiction industrial complex, confronting larger systems of oppression, and contributing to cultural revitalization.
- Recovery and recovery flourishing as acts of rebellion elevate these experiences to something greater than oneself, elevating the journey into and beyond recovery into something more epic, more heroic.
- Recovery initiation and recovery flourishing can be fueled by catalytic metaphors (epiphanies that provoke radical reinterpretations of self and the self-world relationship) that differ widely across recovery-seeking populations.

**Temporal Dimensions of Recovery Flourishing**

- Temporal aspects of recovery and recovery flourishing include the timing of the onset of change, the duration of change efforts, and the rate of change over time (i.e. the potential for exponential growth or decay).
- The onset of recovery is immediately disruptive due to the radical changes it demands in one's daily life. It is quickly corrective, meaning that many dimensions of suffering subside with the reduction or cessation of drug use. It is slowly constructive, meaning that time is required to move beyond repair (problem subtraction) to create a new life (asset development, identity and lifestyle reconstruction). And it is potentially transformative, meaning that flourishing in recovery is attainable as an outcome of change efforts across multiple life domains.
- As a professional field of inquiry and practice, we know very little about the transition from incremental growth in recovery to a state of flourishing.
- The end of each stage of recovery stirs growing discontent signaling an imbalance requiring new adjustments that facilitate entry into the next chapter of one's life. The difference between being frozen in recovery and flourishing in recovery is a willingness and capacity to listen and assertively respond to such signals.
- Post traumatic growth, elevations in psychological health and hardiness, and flourishing occur through processes of transformative change (unplanned, climactic, positive, and permanent) and through incremental change (positive changes unfolding in stages over an extended time).
- Temporal aspects of recovery flourishing include the power of small changes whose effects are compounded over time, not unlike the power of compound interest in a savings account. This raises the potential for exponential recovery growth or decay.

**Family and Community Space/Landscapes: The Ecology of Recovery Flourishing**

- Addiction, remission, recovery, and post recovery flourishing are often portrayed as intrapersonal processes, but these experiences are nested within physical, psychological, social, spiritual, and cultural spaces that can inhibit or promote their achievement and maintenance. Those spaces encompass family/home, neighborhood, neighborhood, school, work, leisure, faith, community, and culture.
- Innumerable studies suggest that family and social support play a critical role in SUD recovery initiation and maintenance and quality of life in early recovery, but it remains unclear whether such support mediates recovery flourishing or if this experience is mediated primarily by intrapersonal variables.
- Family flourishing is not an automatic outcome of personal SUD recovery. Even after years of SUD remission, families may not achieve satisfactory

levels of functioning. Flourishing requires overcoming the strain of family restructuring following recovery initiation, the potential strain of discordant partner drug use, and the strain imposed by discordant partner and family growth.

- Expanding recovery support resources that enhance the experience of connection and community may have exponential value based on the diminishment of such connections within traditional settings: family, extended family, neighborhoods, schools, workplaces, and places of faith. Communities of recovery can thus be thought of as replacement institutions that support global health, social functioning, community inclusion, and human flourishing.
- Post traumatic growth and flourishing in addiction recovery are often experienced as a process of shared healing, replenishment, and growth. Such communal activities include 1) centering rituals, 2) mirroring rituals, 3) acts of self-care and care of one's inner circle, and 4) unpaid acts of service to others.
- Recovery flourishing calls for a new social contract between the individual and the community that involves key principles (restorative justice, forgiveness) and practices (amends, restitution, civic contribution).
- Individuals and families in recovery from addiction ("wounded healers") constitute valuable community assets.

**Cautions Related to Flourishing Research**

- It cannot be assumed that all research findings on recovery flourishing will be positive. It could be demoralizing for people seeking and in recovery if future research revealed that such flourishing is a rare phenomenon or that flourishing is only likely to occur years after recovery initiation.
- Excessive popularization of the concept of recovery flourishing could set recovery expectations at unrealistic levels, particularly for individuals so severely damaged as to make reaching a state of flourishing less likely or more a more complex and prolonged process.
- Casting levels of recovery growth and flourishing into categories of superiority and inferiority could have adverse consequences given that many factors influencing recovery achievements are beyond an individual's control. Such superiority/inferiority categorization risks creating intragroup stigma and a disruptive new class structure within communities of recovery.
- Over-popularization of the recovery flourishing concept could render the concept a "flavor of the month" phenomenon within the addictions field only to then be cast aside as the newest fad topic arises.
- There is the potential of finding that what looks on the surface like flourishing is substitution of one excessive/compulsive behavior for another.

## Implications for Service Design, Delivery and Evaluation

- The potential service design and clinical implications of recovery flourishing span such areas as representation of people with lived experience of recovery flourishing within the addiction treatment and recovery support services workforce, integrating standard assessment and post-service measures of recovery flourishing, patient/family/public education about recovery flourishing, expanding access to activities that open pathways to recovery flourishing within in-treatment and post-treatment recovery support services, and integrating research findings on recovery flourishing into national and local anti-stigma campaigns.

## Conclusion

- Recovery flourishing is a global state of health, an elevated level of social functioning, and a heightened personal/family experience of meaning and purpose. This experience/state/practice is portrayed as a progressive process of growth within, and increasing balance between, multiple life domains. Recovery flourishing emerges via diverse pathways of experience, shares many common qualities, but also unfolds in many yet to be identified varieties across diverse populations and cultural contexts.
- Recovery pessimism is the lie that must be forever expunged from cultural consciousness. The reality, revealed by a growing body of scientific research and legions of people putting a public face and voice on recovery, is that: 1) sustained SUD remission is a widespread phenomenon—the normative outcome for substance use disorders, 2) SUD remission is often accompanied by enhancements in global health and social functioning, and 3) many people in SUD remission/recovery go on to experience lives of significant achievement, community contribution, and personal meaning and fulfillment.
- The growing awareness of the existence of flourishing within the experience of addiction recovery has potentially important implications for affected individuals and families, service providers, local communities, and drug policy makers. It is hoped that the observations shared about such transformations will inspire increased study of this phenomenon and its potential recovery support implications and applications.

## Post Traumatic Growth and Flourishing in Addiction Recovery: A Scoping Review and Commentary

"No tree can grow to heaven unless its roots reach down to hell." — Carl Jung

### Introduction

Addiction, the term commonly used to depict the most severe, complex, and prolonged substance use disorders (SUDs)[2], inflicts well-documented trauma upon individuals, families, and communities.[3] While the prevalence and pathways of addiction recovery initiation have received increasing attention in recent years,[4] far less attention has focused on individual/family flourishing as a potential outcome of addiction recovery.[5] Such interest is increasing under the influence of the Recovery Research Institute and the National Institute on Drug Abuse Consortium on Addiction Recovery Science (CoARS), as is advocacy to alter the language of the addictions field to reflect such flourishing potential.[6]

The term *recovery* literally conveys the retrieval of lost health and functioning, whereas the concept of *recovery flourishing* suggests the possibility of achieving levels of health and functioning far greater than that which existed prior to the addiction and recovery experiences.[7] The metaphoric image of recovery transformation is the uncomely caterpillar (addicted self) withdrawing into a cocoon (recovery

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[2] DSM5 SUD diagnostic criteria, any 6 or more of 11 defining symptoms within a twelve-month period meets severe level, herein characterized as addiction.

[3] GBD 2016 Alcohol and Drug Use Collaborators. The global burden of disease attributable to alcohol and drug use in 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet Psychiatry*. 2018 Dec;5(12):987-1012. doi: 10.1016/S2215-0366(18)30337-7. Erratum in: Lancet Psychiatry. 2019 Jan;6(1):e2. doi: 10.1016/S2215-0366(18)30488-7. PMID: 30392731; PMCID: PMC6251968.

[4] Best, D., Vanderplasschen, W., van de Mheen, D….Nagelhout, G.E. (2018). REC-PATH (Recovery Pathways): Overview of a four-country study of pathways to recovery from problematic drug use. *Alcoholism Treatment Quarterly*, 36(4), 517-29. DOI: 10.1080/07347324.2018.1488550; Flaherty, M. T., Kurtz, E., White, W. L., & Larson, A. (2014). An interpretive phenomenological analysis of secular, spiritual, and religious pathways of long-term addiction recovery. *Alcoholism Treatment Quarterly*, 32(4), 337-356; Kelly, J. F., Hoeppner, B. B., Bergman, B. G., Vilsaint, C. L. (2017) Recovery from substance use disorder in the United States: prevalence, characteristics, and pathways from the first national probability-based sample. *Alcoholism: Clinical & Experimental Research*, 41, 179A; Kelly, J. F., Belisario, K. L., MacKillop, J. (2025). Prevalence, predictors, correlates, and dynamic changes in the NIAAA-defined "recovery" definition. *Alcohol Clin Exp Res* (Hoboken). Sep 24. doi: 10.1111/acer.70172. PMID: 40990872.

[5] Parker, P., Banbury, S., & Chandler, C. (2018). The utility of measuring flourishing in substance and alcohol use disorders research: a systematic review. *European Journal of Applied Positive Psychology*, 2, 5, 1-13. http://www.nationalwellbeingservice.org/volumes/volume-2-2018/volume-2-article-5/

[6] Sheidow, A. J., Hoeppner, B. B., Pack, R. P., Unick, G. J. and Blum, K. (2025) Editorial: Innovations in recovery science: pathways, policies, and platforms that promote thriving after addiction. *Front. Public Health*, 13:1731271. doi: 10.3389/fpubh.2025.1731271; Spiehs, J., Conner, S. (2018). Considerations for substance-use disorder language: cultivating a shift from 'addicts in recovery' to 'people who thrive'. *J Public Health Policy*, Aug;39(3):372-378. doi: 10.1057/s41271-018-0127-y. PMID: 29743656.

[7] Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress*, 17(1), 11–21. doi:10.1023/B:JOTS.0000014671.27856.7e

incubation/gestation/metamorphosis) to then emerge as a butterfly of uncommon beauty and graceful carriage (recovery flourishing). Such images, affirmed through acts of recovery storytelling, offer promise of potential growth and flourishing within the recovery experience. Discussions of the potential for recovery flourishing and how it can best be achieved are rare in the clinical literature of addiction treatment but prominent in the literature of recovery mutual aid organizations.[8] Flourishing in AA and NA are referred to as "living sober," "living clean," the "joy of living," or "living life on life's terms"; in Women for Sobriety as "recognizing life's priorities: emotional and spiritual growth, self-responsibility", in SMART Recovery as "leading a balanced life"; and in Recovery Dharma as a "lifelong journey of growth and awakening."

There is also growing consensus within the medical and scientific communities that recovery is more than the reduction or elimination of pathology (i.e. SUD remission) within an otherwise unchanged life.[9] Recovery flourishing involves processes of subtraction (a foundational state of problem reduction/elimination),[10] addition (enhanced global health and social functioning), and multiplication (growth synergies that produce

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[8] Alcoholics Anonymous World Services, Inc. (AAWS, 2019). *Living Sober*. New York, NY; Narcotics Anonymous World Services (NAWS, 2012) *Living Clean*. Vany Nuys, CA; Women for Sobriety (WFS, 2025). Levels of recovery. Accessed December 14, 2025 at https://womenforsobriety.org/new-life-program/levels-of-recovery/; Horvath, A. T., Rubinas, P. J., & Diodato, L. (2025). *SMART Recovery 4-Point Program Handbook* (4th ed.). SMART Recovery Global.

[9] 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., Stunz, A., & Kaskutas, L. A. (2016). Developing an experiential definition of recovery: Participatory research with recovering substance abusers from multiple pathways. *Substance Use & Misuse*, 51(9), 1116–1129. http://doi.org/10.3109/10826084.2016.1160119; Brophy, H., Dyson, M., & Katherine, R. K. (2023). Concept analysis of recovery from substance use. *Int J Ment Health Nurs*, 32(1), 117-127; DiClemente, C. C. (2013). Paths through addiction and recovery: The impact of spirituality and religion. *Substance Use & Misuse*, 48(12), 1260–1261. doi:10.3109/10826084.2013.808475; Esteban-Rodríguez, L., Pérez-López, M., Sion, A., Olmos-Espinosa, R., Jurado-Barba, R., Maldonado-Sánchez, D., León-Gayo, M., Armada, V., Rubio, G. (2024). Agreement for recovery: First Spanish consensus on the concept of alcohol addiction recovery. *Actas Esp Psiquiatr*., Aug;52(4):382-393. doi: 10.62641/aep.v52i4.1633. PMID: 39129690; PMCID: PMC11319745; Kaskutas, L. A., Borkman, T., Laudet, A., Ritter, L., Witbrodt, J., Subbaraman, M., . . . Bond, J. (2014). Elements that define recovery: The experiential perspective. *Journal of Studies on Alcohol and Drugs*, 75(6), 999-1010; Kelly, J. F., & Hoeppner, B. (2014). A biaxial formulation of the recovery construct. *Addiction Research & Theory*, 23(1), 5-9; Martinelli, T. F., Roeg, D. P. K., Bellaert, L., Van de Mheen, D., Nagelhout, G. E. (2023). Understanding the process of drug addiction recovery through first-hand experiences: A qualitative study in the Netherlands using lifeline interviews. *Qual Health Res*, Aug;33(10):857-870. doi: 10.1177/10497323231174161. PMID: 37279186; PMCID: PMC10426251; Monteiro, V., Bloc, L., Messas, G. (2024). What is it like to be in alcohol addiction recovery? A dialectical phenomenological analysis. *Psychopathology*., 57(5):377-388. doi: 10.1159/000538267. PMID: 38754403; White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33(3), 229-241. doi: 10.1016/j.jsat.2007.04.015; Zemore, S. E., Ziemer, K. L., Gilbert, P. A., Karno, M. P., & Kaskutas, L. A. (2023). Understanding the shared meaning of recovery from substance use disorders: New findings from the What is Recovery? Study. *Substance Abuse: Research and Treatment*, 17, 1–12. doi: 10.1177/11782218231199372

[10] What in Narcotics Anonymous is referred to as "cleaning up the wreckage". Narcotics Anonymous World Services (NAWS, 2012) *Living Clean*. Vany Nuys, CA, p. 16.

heightened levels of meaning and social contribution)[11]—a combination of hedonic well-being (positive feelings) and eudaimonic well-being (functional health).[12]

Recovery flourishing extends the focus from one of intrapersonal illness and health to how the quality of one's existence is influenced by and in turn influences one's physical, psychological, social, and cultural environment. As we shall see in the pages to come, recovery flourishing can be variably viewed as a process (something one experiences over time), a state of being (something one is—an attitude, accomplishment, status, or quality of character), a destination/pursuit (an aspirational goal), a daily practice (something one does—a method or style of living), and a person-world relationship.

To understand flourishing it is helpful to explore the related concept of post-traumatic stress disorder (PTSD). PTSD is based on the idea that the effects of painful experiences of the past can accumulate, shaping one's perceptions, emotional responses, and behavioral responses to current situations as well as alter broader dimensions of character, identity, and worldview. The potential for flourishing within the experience of addiction recovery raises the question of an opposite process. Could positive recovery experiences accumulate to forge a state of sustained human flourishing? Might post traumatic growth (PTG) in recovery serve as an antidote to the trauma that preceded it? If PTSD involves intrusive and life-disrupting flashback images of past injury, might such images be replaced with images from positive experiences via techniques of thought stopping and thought substitution? If addiction trauma can be epigenetically transferred from parent to child, could resilience be transferred as an outcome of parental flourishing?

To explore such questions, the author first conducted a literature search using multiple databases (PubMed, MEDLINE, Semantic Scholar, ScienceDirect, Web of Science, PsycInfo, and Google Scholar). Key word searches included SUD recovery/remission, flourishing, thriving, post traumatic growth, wellbeing, quality of life, and civic contribution. Citations were identified within these resources that were missed in the original search process, and the author also drew on a recovery research bibliography containing more than 5,000 citations.[13] Finally, the author recorded via journaling his own observations, hypotheses, and unanswered research questions related to recovery flourishing drawn from decades of interviewing, surveying, and observing individuals and families in recovery. The resulting monograph is both an investigation (What does the existing scientific evidence reveal?) and a meditation (How

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[11] White, W. & Kelly, J. F. (2025) Toward a solution-focused addiction science. *Frontiers in Public Health*. 13:1701524. doi: 10.3389/fpubh.2025.1701524

[12] Schotanus-Dijkstra, M., ten Have, M., Lamers, S. M. A., de Graaf, R., & Bohlmeijer, E. T. (2016). The longitudinal relationship between flourishing mental health and incident mood, anxiety and substance use disorders. *The European Journal of Public Health*, 27(3), 563–568. https://doi.org/10.1093/eurpub/ckw202

[13] White, W. L. (2022). Addiction recovery: A selected bibliography of professional publications and scientific studies. Accessed November 19, 2025 at https://www.recoveryanswers.org/recovery-research-bibliography/

can I understand what I have learned and observed?). My hope is that this exploration will inform future research on flourishing within the experience of addiction recovery.

**Why Study Recovery Flourishing?**

If future outcomes of recovery flourishing studies are as positive as preliminary research suggests, professional and public dissemination of such results could potentially: 1) lessen the social stigma attached to addiction recovery, 2) shorten addiction careers by motivating early help-seeking and enhancing service retention, 3) promote recovery optimism and raise the low bar of expectations too often placed on people seeking or living in recovery, 4) elevate the status of the addiction treatment and recovery support workforce, 5) expand educational, occupational, leisure, artistic, and community service opportunities for people in recovery, 6) stimulate expanded mechanisms of support across the stages of long-term personal and family recovery, and 7) extol the role of people in recovery as valued and underutilized community assets.

Perhaps most important of these potential contributions is the added recovery enticement offered to those in active addiction. Such enticement (anticipatory relief, release, and joy) is illustrated by what in Alcoholics Anonymous (AA) is referred to as “the promises.”

> "If we are painstaking about this phase of our development, we will be amazed before we are half way through. We are going to know a new freedom and a new happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves. Are these extravagant promises? We think not. They are being fulfilled among us—sometimes quickly, sometimes slowly. They will always materialize if we work for them."[14]

Other recovery mutual aid organizations extend similar promises. Narcotics Anonymous speaks of the potential for “unlimited growth”[15] and a life “beyond our wildest dreams”[16], and Recovery Dharma points to a day when those seeking recovery may be happy, at

[14] Alcoholics Anonymous World Services (2002). *Alcoholics Anonymous*, (4th edition), pp. 83-84.
[15] Narcotics Anonymous (2008). *Narcotics Anonymous*, Sixth Edition, Narcotics Anonymous World Services, Inc., p. 44.
[16] Narcotics Anonymous, *Living Clean*, (2012): Narcotics Anonymous World Services, Inc., p. xiv; Narcotics Anonymous World Services (NAWS, 2012) *Living Clean*. Vany Nuys, CA, p. 19, 20.

ease, and free from suffering.[17] To achieve such results and fulfill such promises, numerous questions about the experience of recovery flourishing must be answered.

**Recovery Flourishing Definition and Measurement**

There has yet to be consensus on a definition of *recovery* to guide research on recovery and related strategies of problem resolution.[18] The term *flourishing* joins *recovery* and other presently "fuzzy" terms and concepts in the drug problems arena whose definitional boundaries continue to be contested.[19] White, in response to newly proffered definitions of recovery, suggested that any such definition must meet the requirements of precision, inclusiveness, exclusiveness, measurability, acceptability, and simplicity. The same could be said for a definition of flourishing in recovery.[20]

As used in this paper, *flourishing in the context of addiction recovery is an exceptional level of global (physical/cognitive/emotional/relational/spiritual) health, life meaning and purpose, and social/cultural contribution experienced within the constraints of one's limitations and life circumstances.* (For glossary of definitions of terms used in this monograph, see Appendix A.)

Put simply, *flourishing in recovery is the experience of reaching or exceeding one's potential for fulfillment and contribution within and across multiple life domains. As commonly described, flourishing within the experience of addiction recovery involves getting "better than well",* a level of growth that far exceeds the healing of injuries inflicted by drug use (or as Women for Sobriety depicts *living one's best life—a lifelong journey of emotional and spiritual growth*[21] or as depicted in Secular Organizations for Sobriety, "the good life".[22]

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[17] Recovery Dharma Global, Inc. (2023) Recovery Dharma. Second Edition, p. xi. https://drive.google.com/file/d/1Isotp-WlUedFJlKDqjpvO7uKgVsvX3J1/view.

[18] Kelly, J. F., & Stauffer, W. (2025). Utility or futility? Toward an operational definition of addiction "recovery." *Addiction Research & Theory*, 1–8. https://doi.org/10.1080/16066359.2025.2609635; White, W. & Kelly, J. F. (2025) Toward a solution-focused addiction science. *Frontiers in Public Health*. 13:1701524. doi: 10.3389/fpubh.2025.1701524

[19] Kelly, J. F., Bergman, B. G. (2021). A bridge too far: Individuals with regular and increasing very heavy alcohol consumption cannot be considered as maintaining "recovery" due to toxicity and intoxication-related risks. J Addict Med., Jul-Aug 01;15(4):269-271. doi: 10.1097/ADM.0000000000000759. PMID: 33060467; Witkiewitz, K., Pearson, M. R., Wilson, A. D., Stein, E. R., Votaw, V. R., Hallgren, K. A., Maisto, S. A., Swan, J. E., Schwebel, F. J., Aldridge, A., Zarkin, G. A., Tucker, J. A. (2020). Can alcohol use disorder recovery include some heavy drinking? A replication and extension up to 9 years following treatment. *Alcohol Clin Exp Res*., Sep;44(9):1862-1874. doi: 10.1111/acer.14413. PMID: 32761936; PMCID: PMC7540311.

[20] White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33(3), 229-241. doi: 10.1016/j.jsat.2007.04.015

[21] Kirkpatrick, J. (2025). Women for Sobriety New Life Program. Women for Sobriety, Quakertown, PA; Kirkpatrick, J. (2025). The Hungering Heart. Accessed December 29, 2025 at https://womenforsobriety.org/wp-content/uploads/2023/05/The-Hungering-Heart.pdf

[22] Secular Organizations for Sobriety (2025). Guidelines for Secular Recovery Success. Accessed December 29, 2025 at https://sober.com/aa-alternatives-secular-organizations-for-sobriety/.

Recovery flourishing is the opportunity for another chance—an opening to turn one's resurrected life into a personal renaissance. Recovery flourishing, like recovery itself, is more than the absence of addiction; it is the experience and embrace of connection, health, and meaning. Flourishing is best viewed as a process and product of choices rather than as the absence of adversity/tragedy in one's life or the outcome of random good fortune. Flourishing is not a life free from suffering—such a goal is impossible. It is rather to rise above and find meaning and joy beyond the suffering that is an integral part of living, or to put it in Buddhist terms to "not waste our suffering".[23] Flourishing is simultaneously the ongoing act of choice-making, an optimal state of living directly flowing from the consequence of one's choices, and the experience of profound meaning and purpose drawn from those choices.

Key to an understanding of recovery flourishing is the question: "What is the threshold (quantitative and qualitative dimensions) at which post traumatic growth qualifies as a state of flourishing?"[24] What benchmark of comparison is to be used in measuring the degree of flourishing: flourishing compared to earlier stages of one's life, flourishing compared to others at a similar stage of recovery, and/or flourishing compared to others of a similar life stage in the general population?

The definition of recovery flourishing and its related measurement will influence determinations of its prevalence and durability. The lack of a consensus definition of recovery flourishing hinders the development of a specific instrument to measure such an achievement within the experience of addiction recovery. There is presently no such instrument, though there are multiple instruments that measure post traumatic growth and instruments that measure components of recovery flourishing (See Table 1; Source references in Appendix B):

Table 1: Sampling of Instruments to Measure Human Flourishing and Related States

| **Flourishing Measurement Instruments** | **Source** |
|---|---|
| The Post Traumatic Growth Inventory | Tedeschi & Calhoun, 1996 |
| The Stress-related Growth Scale | Park et al., 1996; Armeli et al., 2001 |
| The Thriving Scale | Abraido-Lanza et al., 1998 |
| Perceived Benefit Scales | McMillen & Fisher, 1998 |
| Mental Health Continuum | Keyes et al., 2008 |
| Questionnaire for Eudaimonic Well-Being | Waterman et al. ,2010 |
| The Flourishing Scale | Diener et al., 2010 |
| Comprehensive Inventory of Thriving | Su et al., 2014 |
| PERMA Profiler | Butler & Kern, 2016 |
| Secure Flourishing Index | VanderWeele, 2017 |
| Multidimensional Flourishing Scale | Mesurado et al., 2021 |

[23] Recovery Dharma Global, Inc. (2023) *Recovery Dharma*. Second Edition. P. 64. https://drive.google.com/file/d/1Isotp-WlUedFJlKDqjpvO7uKgVsvX3J1/view.
[24] Hone, L.C., Jarden, A.; Schofield, G.M., & Duncan, S. (2014). Measuring flourishing: The impact of operational definitions on the prevalence of high levels of wellbeing. *International Journal of Wellbeing*, 4(1), 62-90. doi:10.5502/ijw.v4i1.4.

| | |
|---|---|
| The Well-Being Assessment | Weziak-Bialowolska et al., 2021 |
| Digital Flourishing Scale | Janicke-Bowles et al., 2023 |
| **Related Instruments** | **Source** |
| The Satisfaction with Life Scale | Deiner et al., 1985 |
| Psychological Well-Being Scale | Ryff, 1989 |
| The Lancashire Quality of Life Profile | Van Nieuwenhuizen et al., 2001 |
| World Health Organization Quality of Life Assessment Instrument | TWHO, 1998 |
| Injection Drug User Quality of Life Scale | Brogly et al., 2003 |
| Passion Scale | Vallerand et al., 2003 |
| Alcohol Quality of Life | Malet et al., 2006 |
| Meaning in Life Questionnaire | Steger et al., 2006 |
| Drug User Quality of Life Scale | Morales-Manrique et al., 2007 |
| Recovery Capital Scale | White, 2009 |
| Assessment of Recovery Capital | Groshkova et al., 2013 |
| Recovery Capital Questionnaire | Burns & Marks, 2013 |
| Addiction Recovery Questionnaire | Iveson-Brown & Raistrick, 2015 |
| Brief Assessment of Recovery Capital | Vilsaint et al., 2017 |
| REC-CAP | Cano, Best et al., 2017 |
| The Recovery Capital Index | Whitesock et al., 2018 |
| The Recovery Strengths Questionnaire | Rettie et al., 2019 |
| Strengths and Barriers Recovery Scale | Best et al., 2020 |
| Recovery Empowerment Scale | Peterson et al., 2022 |
| Multidimensional Inventory of Recovery Capital | Bowen et al., 2023 |
| The Short Grit Scale | Trinh et al., 2023 |
| interRAI Quality of Life for Mental Health and Addictions | Hirdes et al., 2025 |

The degree to which such instruments can effectively measure flourishing in addiction recovery is unclear. McBurnie and colleagues found that a mainstream instrument used in the measurement of PTG (Tedeschi and Calhoun's Post Traumatic Growth Inventory, PTGI) is, with some modification, applicable to the measurement of PTG in addiction recovery, but they went on to suggest the need for validation of a revised PTGI for individuals in addiction recovery.[25] Carlon found similar challenges applying the PERMA Profiler instrument to measure five positive psychology domains with a SUD recovery population and recommended adaptations of the instrument for future use.[26] Also of relevance is growing body of research that, while not specifically

[25] McBurnie, J., Bell, C., Hurst, N., Chambers, S., Graham-Wisener, L., & Toner, P. (2023). Content validity of the post-traumatic growth inventory: a think-aloud study on capturing recovery from addiction. *Addiction Research & Theory*, 32(4), 255–263. https://doi.org/10.1080/16066359.2023.2256217.
[26] Carlon, H. A. (2022). Finding the positive in recovery: Psychometric properties of a measure of human flourishing in an alcohol use disorder recovery sample. https://digitalrepository.unm.edu/psy_etds/328

focused on flourishing, does explore the effects of SUD remission and recovery on improved quality of personal and family life.[27]

The key challenge confronting research on recovery flourishing is the lack of consensus on precisely what is meant by the term and how its existence and degree can best be measured.[28] Conceptually, flourishing is nested within an umbrella of related ideas: holistic health, subjective wellbeing, quality of life, happiness, life satisfaction, remission, resilience, hardiness, grit, post traumatic growth, recovery, and spirituality. It will not be possible to reach a consensus definition of recovery flourishing without mapping its meaning in relationship to these broader constructs and their related bodies of research and measurement instruments.[29]

Flourishing as a concept embraces the achievement of global (physical, psychological, relational, and spiritual) health and social functioning, but critical questions remain. Does flourishing consist of the presence of any of these components, a particular combination of or balance between these elements, or something more? For example, Redmond et al. suggest that flourishing in mental health requires psychological wellbeing, personal happiness, and positive social connection.[30] What is the tipping point between growth within each domain and the emergence of a holistic

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[27] Best, D., Gow, J., Knox, T., Taylor, A., Groshkova, T., & White, W. (2011). Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its predictors. *Drug and Alcohol Review*, 31(3), 334-441; Bray, J., Aden, B., Eggman, A., Hellerstein, L., Wittenberg, E., Nosyk, B., Stribling, J.C. & Schakman, L. (2017). Quality of life as an outcome of opioid use disorder treatment: A systematic review. *Journal of Substance Abuse Treatment*, 76, 88-93; De Maeyer J, Vandesplasschen W, Lammertyn J, van Nieuwehuizen C, Sabbe B, Broekaert E. 2011. Current quality of life and its determinants among opiate-dependent individuals five years after starting methadone treatment. *Qual Life Res*., 20,139–150; Foster, J. H., Marshall, E. J., & Peters, T. J. (2000). Application of a quality of life measure, the life satisfaction survey (LSS), to alcohol-dependent subjects in relapse and remission. *Alcoholism: Clinical and Experimental Research*, 24(11), 1687-1692; Goshorn, J. R., Gutierrez, D., Dorais, S. (2023). Sustaining recovery: What does it take to remain in long-term recovery? *Subst Use Misuse*, 58(7):900-909. doi: 10.1080/10826084.2023.2196557. PMID: 37026405; Kelly, J. F., Greene, M. C., & Bergman, B. G. (2018). Beyond abstinence: Changes in indices of quality of life with time in recovery in a nationally representative sample of U.S. adults. *Alcoholism: Clinical & Experimental Research*, 42(4),770-780. doi: 10.1111/acer.13604; 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 & Misuse*, 44(2), 227-252. doi: 10.1080/10826080802714462; Missouridou, E., Segredou, E., Stefanou, E., Sakellaridi, V., Gremou, M., Kritsiotakis, E., Kokori, P., Roditi, E., Karahaliou, V., Rizavas, I., Vasiliou, A., Patseas, S., Parissopoulos, S. (2023). Family recovery from addiction and trauma: An interpretative phenomenological analysis of mothers' lived experience. *Adv Exp Med Biol*., 1425:105-117. doi: 10.1007/978-3-031-31986-0_10. PMID: 37581785.

[28] Parker, P., Banbury, S., & Chandler, C (2020). Efficacy of the rediscovery process on alcohol use, impulsivity and flourishing: A preliminary randomised controlled study and preliminary cohort study. *European Journal of Applied Positive Psychology*, 4(13), 1-15; Rule, A., Abbey, C., Wang, H., Rozelle, S., Singh, M. K. (2024). Measurement of flourishing: a scoping review. *Front Psychol*. 2024 Feb 1;15:1293943. doi: 10.3389/fpsyg.2024.1293943. PMID: 38362251; PMCID: PMC10867253.

[29] White, W. & Kelly, J. F. (2025) Toward a solution-focused addiction science. *Frontiers in Public Health*. 13:1701524. doi: 10.3389/fpubh.2025.1701524

[30] Redmond, M. L., Buhrmann, A. S., & Fuller-Thomson, E. (2021). The continuum of recovery from alcohol dependence: From addiction remission to complete mental health. *Substance Use & Misuse*, 56(9), 1320–1331. https://doi.org/10.1080/10826084.2021.1922451

state of flourishing? Are there predictable stages of recovery flourishing? Could flourishing in one recovery arena (e.g., education, work) serve as a catalyst for flourishing in other domains as some studies suggest?[31] Can flourishing exist when one domain (e.g., physical health) is experiencing substantial regression? Is flourishing simply the optimum end of a positive continuum of post-addiction growth or is flourishing something qualitatively different? Is the flourishing whole greater than the sum of its parts—something qualitatively different than cumulative growth? Does flourishing require first decentering addiction within one's life and centering the recovery experience or does flourishing require a third step of also decentering the recovery experience/identity, e.g., "I am more than my addiction, but I am also more than my recovery"? Do definitional elements of flourishing differ across diverse populations and cultural contexts? How is the prevalence of flourishing among people in SUD remission compared to people recovering from other medical disorders and to people in the general population without SUD experience? Is flourishing best measured by objective levels of achievement (its effects), by the level of effort expended, or by the distance one has traveled within the process of change (pre-post flourishing status)?

Each of us inevitably defines what flourishing means in our life and the actions needed to achieve and maintain such a state. That said, at a systems level, such questions, like those related to the definition and measurement of recovery, will require answers as this body of research proceeds. From the standpoint of science and systems evaluation, recovery flourishing must be more than a self-proclaimed status. That will require quantitative, objective measures of when one enters and exits this state. And at a personal level, adjustments to remain within the center of such a state cannot be made if its boundaries of entrance and egress are undefined and unrecognizable.

The prevalence of recovery flourishing is not presently known due to the paucity of prevalence studies, but existing research does suggest two preliminary findings: 1) some individuals in recovery do experience significant achievements within the recovery experience[32], and 2) the prevalence of flourishing in recovery (sometimes referred to as complete mental health) is at present less common among those with a present or past history of drug dependence compared to those in the general population without such a history.[33] Viewed together, one still assert that flourishing is not limited to a rare elite of

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[31] Lynch, T., Rodriguez, W., Eddie, D. (2022). Education and careers were our way out. *J Subst Abuse Treat*., Nov;142:108869. doi: 10.1016/j.jsat.2022.108869. PMID: 36088738; Suiter, S. V. & Wilfong, C. D. (2021). Addiction, recovery, and work: Surviving the daily grind. *Work*. 68(1):149-159. doi: 10.3233/WOR-203364. PMID: 33427716.

[32] Eddie, D., White, W. L., Vilsaint, C. L., Bergman, B. G. & Kelly, J. F. (2021). Reasons to be cheerful: Personal, civic, and economic achievements after resolving an alcohol or drug problem in the United States population. *Psychology of Addictive Behaviors*, 35(4):402-414. doi: 10.1037/adb0000689; Narcotics Anonymous World Services, Inc (NAWS, 2025). 2024 NA membership survey. Van Nuys, CA. Accessed November 13, 2025 at www.na.org.

[33] MacNeil, A., Fuller-Thomson, E. (2023). Factors associated with recovery and flourishing mental health in a national sample of Canadians with a history of illicit drug dependence. *Int J Ment Health Addiction*, 21, 81–95. https://doi.org/10.1007/s11469-021-00579-y

recovery savants but is instead a product of decisions, practices, and perseverance within a recovery supportive environment. Our current global response to addiction is inadequate if the only people who can expect to achieve flourishing are the savants whose flourishing seems to come quickly and with limited effort following SUD remission.

**Addiction, Trauma, Post Traumatic Growth and Flourishing**

*The world breaks everyone and afterward many are strong at the broken places.*
—Ernest Hemingway

Trauma spans a broad spectrum of circumstances, to include historical trauma (oppression), combat, child neglect/abuse/abandonment, experiencing or witnessing violence, accidents, death of a significant person, intimate relationship dissolution, job loss, incarceration, natural disasters, and serious physical or mental illness.[34] The trauma experience spans a singular, life-changing traumatic episode to complex/cumulative trauma involving such adverse factors as early age of onset of trauma, multiple traumatic episodes of long duration, severe life-altering traumatic injuries, multiple perpetrators of injury, and lack of belief or relief following trauma disclosure. Cumulative trauma can beget complex recovery processes. For example, Wernekinck & Yoon in a study of men recovering from childhood sexual abuse and substance use disorder found post-addiction growth reflecting such enduing themes as acceptance, forgiveness, reexamination of the meaning of masculinity, and building a "community of healing".[35]

Addiction onset is often proceeded by earlier trauma whose effects are further amplified by addiction-related trauma, making trauma both a potential cause and consequence of addiction.[36] Addiction is associated with increased risk of premature

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[34] Broekhof, R., Nordahl, H. M., Tanum, L., Selvik, S. G. (2023). Adverse childhood experiences and their association with substance use disorders in adulthood: A general population study (Young-HUNT). *Addict Behav Rep*, Mar 30;17:100488. doi: 10.1016/j.abrep.2023.100488. PMID: 37077505; PMCID: PMC10106480; McMillen, C., Howard, M. O., Nower, L., & Chung, S. (2001). Positive by-products of the struggle with chemical dependency. *Journal of Substance Abuse Treatment*, 20, 69–79. doi:10.1016/S0740-5472(00)00151-3; Mongan D, Millar SR, Brennan MM, Doyle A, Galvin B, McCarthy N. (2025). Associations and mediating factors between adverse childhood experiences and substance use behaviours in early adulthood: A population-based longitudinal study. *Addict Behav*., Feb;161:108194. doi: 10.1016/j.addbeh.2024.108194. PMID: 39522299; Ramos, C. & Leal, I. (2012). Posttraumatic growth in the aftermath of trauma: A literature review about related factors and application contexts. *Psychology, Community & Health*, 1(1), 1-20.

[35] Wernekinck, U, Yoon. S. (2025). "We heal together": Characteristics of the male healing journey from childhood sexual abuse among men in recovery from substance use disorder in the United States. *J Child Sex Abus*., Apr;34(3):280-301. doi: 10.1080/10538712.2025.2494006. PMID: 40247737.

[36] Hammersley, R., Dalgarno, P., McCollum, S., Reid, M., Strike, Y., Smith, A., … Liddell, D. (2016). Trauma in the childhood stories of people who have injected drugs. Addiction Research & Theory, 24(2), 135–151. https://doi.org/10.3109/16066359.2015.1093120; Mardani, M., Alipour, F., Rafiey, H., Fallahi-Khoshknab, M., Arshi, M. (2023). Challenges in addiction-affected families: a systematic review of qualitative studies. *BMC Psychiatry,* Jun 16;23(1), 439. doi: 10.1186/s12888-023-04927-1. PMID: 37328763; PMCID: PMC10273571; McGaffin, B. J., Deane, F. P., Kelly, P. J., & Ciarrochi, J. (2015).

death, deterioration in physical and emotional health, disruption in family and social relationships, lower education and occupational achievement, and increased risk of arrest and incarceration.[37] Addiction trauma shares many aspects of the compromised quality of life seen in other traumatic experiences: subsequent physical/psychiatric complications, damaged sense of self, self-care limitations, family disruption and risk of intimate relationship dissolution, unhealthy assortative mating (i.e. toxic relationships), shattered sense of security, pessimistic life expectations, depletion of social and financial support resources, heightened anxiety and depression, strained capacities for emotional coping, and continued exposure to high-risk environments.[38] Perhaps most traumatic is the spoiling of one's identity via the growing self-belief that one is not just broken or "damaged goods", but irreparable and irredeemable—a belief that can accelerate drug use and its related consequences.[39] Similar injuries are also experienced by family members/caregivers affected by addiction.[40] Some addiction treatment thought leaders posit self-medication of posttraumatic emotional pain as the dominant pathway of addiction initiation and maintenance —an in-the-moment balm for

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Flourishing, languishing and moderate mental health: Prevalence and change in mental health during recovery from drug and alcohol problems. *Addiction Research and Theory*, 23(5), 351–360. http://dx.doi.org/10.3109/16066359.2015.1019346.

[37] MacNeil, A., Fuller-Thomson, E. (2023). Factors associated with recovery and flourishing mental health in a national sample of Canadians with a history of illicit drug dependence. *Int J Ment Health Addiction*, 21, 81–95. https://doi.org/10.1007/s11469-021-00579-y.

[38] Alkan, G., Altin, D., Yararbas, G., Hassoy, H. (2025). Relationship between smoking and marital adjustment & social support among women with spouses experiencing alcohol/substance use disorders. *BMC Womens Health*, Aug 21;25(1):403. doi: 10.1186/s12905-025-03947-1. PMID: 40841890; PMCID: PMC12372376; Bratu, M. L., Sandesc, D., Anghel, T., Tudor, R., Shaaban, L., Ali, A., Toma, A. O., Bratosin, F., Turcu, I., Gantsa, A., Fericean, R. M., Bondrescu, M., Barata, P. I. (2023). Evaluating the aspects of quality of life in individuals with substance use disorder: A systematic review based on the WHOQOL Questionnaire. *J Multidiscip Healthc*., Dec 28;16:4265-4278. doi: 10.2147/JMDH.S440764. PMID: 38164463; PMCID: PMC10758186; Caces, M. F., Harford, T. C., Williams, G. D., Hanna, E. Z. (1999). Alcohol consumption and divorce rates in the United States. *J Stud Alcohol*, Sep;60(5):647-52. doi: 10.15288/jsa.1999.60.647. PMID: 10487734.

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trauma that in turn induces additional trauma.[41] Cumulative traumatic wounds leave many addicted individuals with severe developmental deficits, a minimum of recovery capital (internal and external resources to initiation and sustain recovery,[42] and a prolonged course of recycling through acute episodes of treatment without sustained recovery stabilization.[43]

Even the onset of recovery can be disruptive or distressing given the grief over the lost drug relationship, the severing of drug-related social relationships[44], the radical reconstruction of identity and lifestyle required of recovery-seeking individuals[45], and the subsequent radical realignment of roles, rules, rituals and relationships often experienced by recovering families.[46] Recovery distress includes what one must face

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[41] Khantzian E. J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harv Rev Psychiatry*, Jan-Feb;4(5):231-44. doi: 10.3109/10673229709030550. PMID: 9385000; Khantzian, E. J. (2013). Addiction as a self-regulation disorder and the role of self-medication. *Addiction*, 108(4), 668-669; Maté, D. G. (2018). *In the realm of hungry ghosts*. Vermilion.

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[45] 'De Maeyer J, Vandesplasschen W, Lammertyn J, van Nieuwehuizen C, Sabbe B, Broekaert E. 2011. Current quality of life and its determinants among opiate-dependent individuals five years after starting methadone treatment. *Qual Life Res*., 20,139–150; Dingle, G. A., Haslam, C., Best, D., Chan, G., Staiger, P. K., Savic, M., Beckwith, M., Mackenzie, J., Bathish, R., Lubman, D. I. (2019). Social identity differentiation predicts commitment to sobriety and wellbeing in residents of therapeutic communities. *Soc Sci Med*., Sep;237:112459. doi: 10.1016/j.socscimed.2019.112459. PMID: 31404883; Kitzinger, R. H. Jr., Gardner, J. A., Moran, M., Celkos, C., Fasano, N., Linares, E., Muthee, J., Royzner, G.. (2023). Habits and routines of adults in early recovery from substance use disorder: Clinical and research implications from a mixed methodology exploratory study. *Subst Abuse*., Feb 11;17:11782218231153843. doi: 10.1177/11782218231153843. PMID: 36798446; PMCID: PMC9926005; Patton, D., Best, D., & Brown, L. (2022). Overcoming the pains of recovery: the management of negative recovery capital during addiction recovery pathways. *Addiction Research & Theory*, 30(5), 340–350. https://doi.org/10.1080/16066359.2022.2039912; Pettersen, G., Bjerke, T., Hoxmark, E. M., Eikeng Sterri, N. H., Rosenvinge, J. H. (2023). From existing to living: Exploring the meaning of recovery and a sober life after a long duration of a substance use disorder. *Nordisk Alkohol Nark*. Dec;40(6), 577-589. doi: 10.1177/14550725231170454. PMID: 38045010; PMCID: PMC10688400; White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

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about oneself (e.g., moral condemnation) without the aid of drug-induced emotional anesthesia or the self-protective distortions of memory common in active addiction.[47] What AA refers to as a “searching and fearless moral inventory of ourselves” can, while therapeutic, be emotionally wrenching when undertaken without substantial support.

This recovery reorientation process often results in a reconstruction (or reinterpretation) of one’s life story and social identity.[48] Recovery flourishing involves weaving a new life story (redemptive narrative) that separates and sets one’s old life as prologue to a new life in recovery— a cleaving of one’s life into the categories of *before* and *after*. Such radical reorientation may include a sense of calling and changing one’s life focus toward helping others overcome similar traumatic experiences.[49] That said, more than half of U.S. individuals surveyed who have resolved an alcohol or other drug problem do not identify as being “in recovery”[50], with that proportion embracing such identification being higher (59.18%) among those admitted to specialty addiction treatment.[51] The role of recovery identification in flourishing across those who do and do not embrace such an identity and the related influence of problem severity have yet to be studied.

Recovery from addiction, like recovery from other forms of radical life change, includes the opportunity for unexpected benefits—a level of growth and flourishing that far exceeds pre-addiction levels of achievement.[52] Extolling growth potential within the recovery experience (addiction suffering and recovery initiation as a process of instruction and purification) does not minimize the enormous personal and social costs inflicted by pre-addiction and addiction-related traumas. That said, there is the potential

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[51] Bourdon, J. L., Judson, S., Fields, T., Verdecanna, S., Vadhan, N. P., Morgenstern, J. (2024). Self-reported sobriety labels: Perspectives from alumni of inpatient addiction treatment. *Subst Abuse Rehabil*., Jul 24;15:99-106. doi: 10.2147/SAR.S470780. PMID: 39070773; PMCID: PMC11283828.

[52] Ramos, C. & Leal, I. (2012). Posttraumatic growth in the aftermath of trauma: A literature review about related factors and application contexts. *Psychology, Community & Health*, 1(1), 1-20.

to transform the addiction and recovery experiences into what mythologist Joseph Campbell referred to as the 'heroic journey', in which one leaves home to face great trials, survives innumerable tests and hardships, and then returns to the community to share the lessons learned from one's ordeal.[53] Not only is sustained flourishing possible in the aftermath of adversity, but it might also only be possible as a response to adversity and struggle. White and Kelly recently outlined five patterns of drug problem prevention/resolution (resistance, resilience, risk minimization, remission, and recovery) among those at highest risk for addiction, each of which is a potential precursor to PTG and flourishing (e.g., global health, character enhancement, happiness, and a meaningful life of community contribution).[54]

The potential for post traumatic growth and flourishing even in the most inhospitable environments (e.g., prison) flows from two potential sources. First is the redirection of survival strengths developed through the course of addiction to the demands of recovery initiation and maintenance. Addiction requires devotion, commitment, focus, social network connections, continual knowledge and skill acquisition, and pursuit of personal pleasure—traits in the absence of addiction associated with high levels of prosocial achievement and elements integral to recovery initiation. Second are the strengths (knowledge, perspectives, skills, and relationships) developed through the processes and stages of recovery, e.g., *stronger at the broken and now healing and healed places*. Both sources of strength constitute the foundation upon which recovery flourishing rises.

International surveys of recovery prevalence and life in recovery and recovery mutual aid membership surveys confirm the potential for substantial achievements in the aftermath of recovery initiation.[55] Other more focused studies have documented recovery-linked growth in the arenas of physical health[56], mental health[57], quality of

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family life and positive parenting[58], family reunification[59], positive social relationships[60], reduced criminal justice involvement[61], housing stability[62], financial security[63], educational achievement[64], employment[65], development of new interests[66], positive

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community engagement after criminal justice involvement[67], civic participation and contribution[68], and enhancement of life satisfaction, happiness and gratitude[69]. The time, energy and financial resources once devoted to addiction maintenance can when redirected and focused on growth within the recovery experience contribute to significant recovery achievements that may be limited but not precluded by factors of age, gender, race, and time in recovery.[70] What is unclear is the degree to which such recovery growth meets a threshold of recovery flourishing.

**Recovery Flourishing: Research to Date**

The literature on flourishing within the experience of addiction recovery is most often contained in indirect references within studies of related subjects (e.g., quality of life, well-being) or as an addiction treatment outcome measure (e.g., health, family, employment, etc.). The potential for recovery flourishing is rooted in numerous religious (e.g., Buddhist) and philosophical (e.g., existential, humanist) traditions suggesting strength and meaning rising from adversity and suffering.[71] Abraham Maslow in his conceptualization of a hierarchy of human needs (physiological needs, safety, love and belonging, esteem, and self-actualization) was among the first to suggest the building blocks of human flourishing.[72] His work anticipated later studies suggesting such factors as economic security, employment, housing stability, food security, and educational

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access are potential foundational support for enhanced quality of life and recovery flourishing.[73]

Victor Frankl drew on his concentration camp observations to posit that even in the most traumatic of circumstances one still retains the power to choose one's response to suffering and to forge meaning and purpose from the experience.[74] Seligman and Csikszentmihalyi explored how humans can move beyond adversity by using positive thoughts, emotions, and actions to attain virtue, happiness, and a high level of personal achievement.[75] Csikszentmihalyi subsequently described the value of assertively challenging and transcending adversity and the related potential to achieve *flow*—a state of ecstatic focus linked to high levels of creativity and achievement.[76] Where flow is often used to depict a brief time-suspending out-of-self-experience, flourishing conveys a more enduring lifestyle or what Csikszentmihalyi described as *optimal experience*— "an extended episode of flow: a focused, concentrated, internally coherent, logically ordered set of experiences, which, because of its inner order, was felt to be meaningful and enjoyable".[77] Flourishing in Csikszentmihalyi's view can be thought of as maximizing time in flow and building a lifestyle around such experiences. Seen as a whole, these early studies of *post traumatic growth* (PTG), or *adversarial growth / transformational coping,* set the stage for increased interest in the potential for flourishing in addiction recovery.[78]

McMillen and colleagues identified positive byproducts of early addiction recovery, to include increased self-efficacy, enhanced family and social relationships, increased empathy and compassion, spiritual awakening, and development of a new life

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purpose and priorities.[79] Hart and Sing found that meaning in life was associated with positive recovery and quality of life outcomes.[80] Laudet and colleagues found similar positive outcomes[81] and called for extending traditional post-treatment evaluations focused on pathology reduction to be expanded to assessment of post-addiction quality of life.[82] Kelly et al. found that those achieving recovery in early adulthood had higher levels of functioning and quality of life than those entering recovery at an older age.[83] Hibbert and Best, in a study of 53 recovering problem drinkers, found progressive growth across life domains as the duration of recovery increased, particularly among those in stable (five plus years) recovery and including some areas of achievement that were above their premorbid state and above that found in the general population.[84] Craft and colleagues in a study of individuals recovering from opioid use disorder found quality of life and flourishing mediated by three factors: degree of depression, post-acute withdrawal, and pain.[85] Hoorash and Freedman, Ogilvie and Carlson, and Runyan and colleagues were among the first to apply the concept of PTG to the potential for flourishing within addiction recovery.[86] Krentzman and Ogilvie independently explored

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[80] Hart, K. E., & Singh, T. (2009). An existential model of flourishing subsequent to treatment for addiction: The importance of living a meaningful and spiritual life. *Illness, Crisis & Loss*, 17(2), 125-147. https://doi.org/10.2190/IL.17.2.d

[81] 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; 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 & Misuse*, 43(1), 27-54. doi: 10.1080/10826080701681473; White, W.L., Laudet, A.B. & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional*, 4(4), 18-23.

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the broader application of positive psychology to addiction recovery.[87] Ogilvie and Hennesy et al. proposed a model of G-CHIME (growth through connectedness, hope, identity, meaning in life, and empowerment) to conceptualize recovery growth and flourishing.[88] These studies were accompanied by specific calls for research on the potential for flourishing in the aftermath of illness[89] and as an unexplored outcome of addiction recovery.[90]

Parker and colleagues were the first to evaluate an intervention (The Rediscovery Process, RTP) specifically designed to encourage flourishing within the experience of addiction recovery.[91] The RTP intervention was linked to reduced alcohol use and increased flourishing, including reduced impulsivity, increased physical and emotional health, increased quality of life, and increased recovery capital. Programs with similar aims have also been positively evaluated (e.g., the Moving On In My Recovery program,[92] the Leap for Well-being and Recovery program[93], and Positive Addiction Recovery Therapy.[94] Demirci et al. in a study of AA members in Turkey, found high levels of AA participation linked to flourishing, hope, and perceived social support

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[87] Krentzman, A. (2013, March). Review of the application of positive psychology to substance use, addiction, and recovery research. *Psychology of Addictive Behaviors*, 27(1), 151–165. https://doi.org/10.1037/a0029897; Krentzmann A. R., Bowen, E. A., Zemore, S. E. (2024). Happiness with recovery from alcohol and substance use disorders predicts abstinence and treatment retention. *J Posit Psychol*. 2024 Nov 20:10.1080/17439760.2024.2431686. doi: 10.1080/17439760.2024.2431686. PMID: 40918746; PMCID: PMC12413015; Ogilvie, L. (2024). A positive approach to recovery from drug and alcohol addiction. PhD dissertation, University of Bolton. https://ub-ir.bolton.ac.uk/esploro/outputs/doctoral/A-positive-approach-to-recovery-from/999705208841.

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[93] Ramos, S. D. A. & Bernardo, A. B. I. (2025). Leap for Well-being and Recovery: Effects and mechanisms of a locus-of-hope enhancement program for people with substance use disorders. *International Journal of Applied Positive Psychology*, 10, https://api.semanticscholar.org/CorpusID:276262047.

[94] Ogilvie L, Carson J (2023). Positive addiction recovery therapy: a replication and follow-up study. *J. Advances in Dual Diagnosis*, 0.1080/14659891.2021.1905093 https://doi.org/10.1080/14659891.2021.190509

as well as decreased stress and depression.[95] Heinrich et al. in a study of an active sober community (The Phoenix) found the following dimensions increasing over time in recovery and duration of participation: happiness and life satisfaction, mental and physical health, meaning and purpose, character and virtue, close social relationships, and financial and material security.[96]

In a systematic review of the broader positive psychological interventions in SUD treatment settings, Carlon and colleagues found high acceptability ratings but insignificant positive psychological health and SUD outcomes.[97] Wang et al. explored the relationship between Buddhist-inspired practices within Recovery Dharma and recovery outcomes.[98] They found that emotional self-regulation skills (e.g., meditation) increased recovery capital, which in turn elevated recovery outcomes. Apsley and colleagues found that participation in a recovery community center increased holistic health via strengthening participants' recovery identity and sense of meaningfulness.[99]

What is clear from research to date is that flourishing is not the complete absence of the physical legacies of addiction (craving, post-acute withdrawal, addiction-related illnesses, injuries, or inattention to nutrition, exercise, sleep, and basic health maintenance). It is the achievement of optimum health within the limits imposed by one's life circumstances and the capacity to rise above and draw meaning from any such limitations.

### Flourishing within a Spectrum of Wellbeing and Social Functioning

The potential for flourishing within the experience of addiction recovery is best appreciated within the larger spectrum and gradations of illness and health (Parker et al., 2018). This continuum can be portrayed as overlapping stages in which one can progress or regress, as indicated in Table 2.

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[95] Demirci, S. C., Menkü, B. E., Aksoy, N., Özaslan, A., Arıkan, Z. (2025). The effect of alcoholics anonymous group participation on flourishing in Turkey: the mediating role of hope and social support. *BMC Psychiatry*, Nov 28;25(1):1197. doi: 10.1186/s12888-025-07667-6. PMID: 41316125; PMCID: PMC12750931.

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Table 2: Spectrum of Global Wellbeing and Social Functioning

| **Wellbeing Status** | **Related Language Descriptors** | **Definition** |
|---|---|---|
| Suffering | sickness, agony, despair | a progressive deterioration in global (physical, psychological, relational, spiritual) health and social functioning often accompanied by increased risk of self-harm |
| Languishing | lethargy, flounder, decline, discontent, stuck, going nowhere, limbo, treading water, stagnation, withering, passivity (living mechanically), dry drunk | a state of lost vitality and dissatisfaction related to one's health and life situation often manifested by discontent, irritability, self-pity, resentment, futility, and complacency. |
| Functioning | hanging in, making it, doing okay, coping | a state of health and social functioning comparable to others within one's stage of life in the general population |
| Growing | post traumatic growth, stretching, expanding; quality of life improvement; grit; hardiness | progressive enhancement of global (physical, psychological, relational, spiritual) health and social functioning |
| Flourishing | Amplified (transcendent) recovery, thriving, self-actualization, better than well, optimum (or complete) wellbeing, complete (or positive) mental health, harmony, emotional sobriety, serenity, flow, bliss, in the zone | a state of peak global (physical, psychological, relational, spiritual) health, personal achievement, fulfillment, and social contribution |

These categories can be applied to the evaluation of functioning within specific life domains, e.g., intimate and family relationships, social relationships, physical health, emotional health, etc. and within specific contexts, e.g., home, education, work, community. What is critical is that growth domains within the above spectrum are linked

to stability of recovery and quality of life in recovery across the stages of recovery.[100] Suffering and flourishing represent the endpoints of a scale of personal well-being, global health, and social functioning.

**Growth, Flourishing and SUD Status**

Expected achievements in addiction recovery involve: 1) achieving/sustaining SUD remission, 2) experiencing reductions in SUD-related distress (e.g., diminishment of post-acute withdrawal and drug craving) 3) progressive reductions in addiction-related impairments (e.g., neurological repair, emotional regulation), 4) incremental improvement in global health and social functioning, and 5) progress in maintaining (or repairing) a positive person-community relationship. Wallace suggests such progress is dependent on time and work/growth in recovery, with early recovery often characterized by primitive defenses that once supported addiction (e.g., denial, black/white thinking, projection of blame, etc.).These defenses are reframed to support early recovery only to later be abandoned for more mature coping strategies that can pave the way to greater functional health and happiness.[101]

As for flourishing, one can achieve an overall state of recovery flourishing or achieve remarkable gains in one area but not in others. Also, the relationship between the above states and SUD status can be a complex one as indicated by: 1) people in active addiction who are able to sustain a pattern of growth or flourishing in some areas of their lives for some time in spite of other areas experiencing addiction-related deterioration, 2) people who achieve SUD remission but who continue to experience adversity (e.g., persistent pain[102]) or a state if languishing (e.g., experience physical/emotional pain and a lack of personal growth or social contribution[103]), and 3) people in SUD recovery who later regress to a state of languishing (e.g., “dry drunk” in

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[103] “…we have observed some members who remain abstinent for long periods of time whose dishonesty and self-deceit still prevent them from enjoying complete recovery and acceptance in society.” Narcotics Anonymous (2008*). Narcotics Anonymous*, Sixth Edition, Narcotics Anonymous World Services, Inc., p. 77; Mayock, P., Butler, S. (2021). Pathways to 'recovery' and social reintegration: The experiences of long-term clients of methadone maintenance treatment in an Irish drug treatment setting. *Int J Drug Policy*, Apr;90:103092. doi: 10.1016/j.drugpo.2020.103092. PMID: 33429162.

the language of AA).[104] The latter state suggests that a person can be drug free but not yet free, meaning that he or she remains held by an insatiable hunger and its hold on mind and body—trapped between the opposing forces of desire for relief and desire for release. What is needed in the face of such entrapment is a catalytic experience that can propel one to another level of recovery, a level of recovery flourishing.

Flourishing and distress can coexist and progress to stable flourishing; flourishing can regress to a state of languishing or suffering. The boundaries between these states of illness, health and thriving are at present ill-defined but observed to be fluid and amenable to change, sometimes quite quickly. SUD remission is an important predicate to flourishing potential. In a 2015 study, McGaffin and colleagues found 53% of their recovery sample met criteria for flourishing, while only 29% of those still using drugs met that criteria.[105] Eddie and colleagues compared abstinence versus non-abstinence pathways of AOD problem resolution in the U.S. population and their relationship to social functioning, quality of life, and well-being.[106] The abstinence style of remission was associated with greater self-esteem, happiness, quality of life, and social

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functioning—findings similar to that found in studies by LoCastro et al.[107], Subbaraman & Witbrodt[108], Hagen et al.[109], Amin-Esmaeili et al.[110], and Kelly et al.[111].

Witkiewitz et al., in a study of individuals being treated for alcohol use disorder, found seven subpopulations by drinking status: persistent heavy drinking, abstinence to heavy drinking, abstinence and heavy drinking, heavy drinking to mostly abstinent, low risk and heavy drinking, abstinence and low risk drinking, and abstinence.[112] At follow-up,[113] there were four identified subgroups: low-functioning frequent heavy drinkers, low-functioning infrequent heavy drinkers, high-functioning heavy drinkers, and high-functioning infrequent drinkers, with the latter category making up half of the sample. While not specifically focused on flourishing, the Witkiewitz studies confirm the potentially complex relationship between drug use status and level of functional

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[108] Subbaraman, M.S. & Witbrodt, J. (2014) Differences between abstinent and non-abstinent individuals in recovery from alcohol use disorders. *Addictive Behaviors*, 39, 1730–1735.

[109] Hagen, E., Erga, A. H., Hagen, K. P., Nesvåg, S. M., McKay, J. R., Lundervold, A. J., Walderhaug, E. (2017). One-year sobriety improves satisfaction with life, executive functions and psychological distress among patients with polysubstance use disorder. *J Subst Abuse Treat*., May;76:81-87. doi: 10.1016/j.jsat.2017.01.016. PMID: 28159440.

[110] Amin-Esmaeili, M., Farokhnia, M., Susukida, R., Leggio, L., Johnson, R. M., Crum, R. M., Mojtabai, R. (2024). Reduced drug use as an alternative valid outcome in individuals with stimulant use disorders: Findings from 13 multisite randomized clinical trials. *Addiction*, May;119(5):833-843. doi: 10.1111/add.16409. Erratum in: Addiction. 2024 Oct;119(10):1849-1852. doi: 10.1111/add.16590. PMID: 38197836; PMCID: PMC11009085.

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[112] Witkiewitz, K., Kirouac, M., Roos, C. R., Wilson, A. D., Hallgren, K. A., Bravo, A. J., Montes, K. S., & Maisto, S. A. (2018). Abstinence and low risk drinking during treatment: Association with psychosocial functioning, alcohol use, and alcohol problems 3 years following treatment. *Psychology of Addictive Behaviors*. http://dx.doi.org/10.1037/adb0000381

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health[114]. This relationship is also significantly influenced/complicated over time by the presence of cooccurring psychiatric disorders[115] and by variations in recovery capital.[116]

It is clear from studies to-date that most individuals with lower substance use disorder severity achieve SUD remission without professional intervention, but little is known about the degree of growth and flourishing related to such remissions.[117] Mellor and colleagues found that such individuals make narrative sense of such changes via flourishing-linked themes identified earlier (e.g., emancipation, discovery, mastery, or coping).[118] Zemore et al. and Gilbert et al. also reported differences in recovery experiences across the spectrum of problem severity, abstinent-versus non-abstinent SUD remission, and degree of past exposure to addiction treatment and recovery mutual aid groups.[119]

Addiction suffering and moderate functioning in early recovery have each been well-documented in the addiction and addiction treatment outcome literature, while the experiences of languishing and flourishing within the long-term addiction recovery process remain under-investigated. Addiction is a crushing experience—one that often leaves one mired in hopelessness, helplessness, and dependency. Recovery flourishing is not just the remediation of these states but their replacement with hope and assertive and positive life engagement. While recovery initiation is often seen as a pain quotient ("hitting bottom"), it is possible that some people seek recovery from aspirations rising within the experience of flourishing in other domains of their life (e.g., hope and purpose

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[114] Also see Cunningham, J. A., Schell, C., Walker, H., Godinho, A. (2024). Patterns of remission from alcohol dependence in the United Kingdom: results from an online panel general population survey. *Subst Abuse Treat Prev Policy*, Jan 4;19(1):3. doi: 10.1186/s13011-023-00588-1. PMID: 38178169; PMCID: PMC10768276.

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[118] Mellor, R., Lancaster, K., Ritter, A. (2021). Recovery from alcohol problems in the absence of treatment: a qualitative narrative analysis. *Addiction*, Jun;116(6):1413-1423. doi: 10.1111/add.15288. PMID: 33037842.

[119] Zemore, S. E., Ziemer, K. L., Gilbert, P. A., Karno, M. P., & Kaskutas, L. A. (2023). Understanding the shared meaning of recovery from substance use disorders: New findings from the What is Recovery? Study. *Substance Abuse: Research and Treatment*, 17, 1–12. doi: 10.1177/11782218231199372; Gilbert, P. A., Soweid, L., Evans, S., Brown, G. D., Skinstad, A. H., Zemore, S. E. (2024). How recovery definitions vary by service use pathway: Findings from a national survey of adults. *Psychol Addict Behav*., Dec;38(8):891-900. doi: 10.1037/adb0001026. PMID: 39133610; PMCID: PMC11563847.

versus pain as a recovery catalyst)[120]. In other words, flourishing may be both a catalyst and consequence of recovery.

It is hypothesized that movements in the direction of flourishing, like turning points in recovery initiation[121], are most often preceded by increases in recovery capital, whereas regression toward languishing may be triggered by key developmental shifts, e.g., new trauma/loss experiences, empty nest, divorce, career stagnation, retirement, relocation, etc. Incremental indicators of recovery languishing constitute an early warning system that can spark adjustments in recovery maintenance strategies.[122]

**Domains of Recovery Flourishing**

Domains have not yet been established specific to flourishing in addiction recovery, nor have such domains been tested across a diversity of demographic populations, cultural contexts, and recovery pathways. Numerous questions remain. Does the nature, prevalence, and degree of achievement of recovery flourishing differ across secular, spiritual, and religious pathways of recovery and their representative treatment and recovery support institutions? Are there, for example, differences in recovery flourishing among those in recovery from opioid addiction based on the use or nonuse of medications for opioid use disorders (MOUD)? (Studies of the effects of MOUD on recovery flourishing have yet to be conducted, but there are studies that note enhanced quality of life, including multiple factors earlier noted as dimensions of flourishing, that are linked to MOUD retention and adherence.[123] Are flourishing experiences and pathways different for recovering adolescents, women, BIPOC (Black, Indigenous, and people of color), members of the LGBTQ+ community, or other

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[121] Bellaert, L., Van Steenberghe, T., De Maeyer, J., Vander Laenen, F., & Vanderplasschen, W. (2022). Turning points toward drug addiction recovery: contextualizing underlying dynamics of change. *Addiction Research & Theory*, 30(4), 294–303. https://doi.org/10.1080/16066359.2022.2026934

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historically marginalized groups? Halik et al. and Batchelder et al., in a SUD recovery survey of U.S. sexual minorities, found such minorities experiencing greater challenges in recovery and lower ratings of wellbeing.[124] Vose-O'Neil et al. found similar challenges experienced within the Black community with many individuals stuck in an early stage of recovery without flourishing opportunities.[125] The flourishing experiences of groups that have been historically marginalized in both the mainstream culture and within drug cultures, e.g., women and LGBTQ+ have yet to be thoroughly investigated.[126] Are there, for example, specific issues addressed within the experiences of recovering women that promote flourishing beyond achievement of SUD remission (e.g., physical/psychological safety, gender-specific addiction/recovery stigma, gender role expectations, body image, mate selection, mother-child relationships, etc.)?[127] Is growth within and across domains synchronous or asynchronous over time? Vederhous et al., for example, found growth within partnership relationships lagging other domains of growth within the recovery experience.[128]

The Native American Wellbriety movement suggests four directions of growth within the experience of addiction recovery: emotional, mental, physical, and spiritual growth that unfold over space and time within the life cycle.[129] Potential benefits of post traumatic growth and flourishing in addiction recovery span at least five domains: 1) deepened recovery resolve and new priorities flowing from personal survival, new appreciation of life, and a sense of rebirth (new sense of self), 2) enhanced empathy,

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[124] Haik, A. K., Greene, M. C., Bergman, B. G., Abry. A. W., Kelly, J. F. (2022). Recovery among sexual minorities in the United States population: Prevalence, characteristics, quality of life and functioning compared with heterosexual majority. *Drug Alcohol Depend*., Mar 1;232:109290. doi: 10.1016/j.drugalcdep.2022.109290. PMID: 35032857; PMCID: PMC8885881; Batchelder, A. W., Claire Greene, M., Scheer, J. R., Foley, J., Jenny Shin, H. J., Koehn, K. M., Kelly, J. F. (2024). Sexual minority disparities in psychosocial functioning following substance use recovery among a representative sample of US adults. *Addict Behav Rep*., Jan 4;19:100527. doi: 10.1016/j.abrep.2024.100527. PMID: 38226009; PMCID: PMC10788780.

[125] Vose-O'Neal, A., Christmas, S., Alfaro, K. A., Dunigan, R., Leon, A. P., Hickman, D., Johnson, A., Kim, M. L., Reif, S. (2025). Understanding pathways to recovery from alcohol use disorder in a Black community. *Front Public Health*, May 1;13:1537059. doi: 10.3389/fpubh.2025.1537059. PMID: 40376060; PMCID: PMC12078236.

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[128] Vederhus, J. K., Pripp, A. H.; Clausen, T. (2016). Quality of life in patients with substance use disorders admitted to detoxification compared with those admitted to hospitals for medical disorders: Follow-up results. *Subst Abuse,* 10, 31-7.

[129] White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO.

tolerance, deepened relationships, and greater emotional expression/connections, 3) enhanced awareness of previously unrecognized personal strengths and limitations, 4) enhanced spirituality, and 5) a new optimistic life path.[130] These domains suggest the potential within the recovery process of moving far beyond a fundamental reconstruction of the person-drug relationship to a radical reconstruction of personal character, worldview, values and identity; a reconstruction of family and interpersonal relationships; and reconstruction of the person-community relationship.[131]

Such achievements have been theoretically attributed to strengthening of character and coping abilities as a result of trauma survival, increased hardiness as preparation and a protective shield against future adversity, and creation of a more resilience-enhancing worldview (e.g., vulnerabilities, limitations, possibilities, choices, meaning and purpose) that incorporates the trauma and recovery experiences).[132] Ogilvie and Carson's G-CHIME (Growth, Connectedness, Hope, Identity, Meaning in life and Empowerment) model of addiction recovery is suggestive but did not distinguish general growth in recovery from a heightened state of flourishing across the domains they identified.[133] What separates PTG within these categories from a state of flourishing is the potentially high degree of achievement, self-fulfillment, and social contribution within the latter experience.

Future studies to confirm the domains of recovery flourishing could be informed by earlier work on flourishing within the general population. Martin Seligman (2011), a leading pioneer in the study of human flourishing, developed the PERMA model which posited five building blocks of flourishing: positive emotions, engagement, relationships, meaning and accomplishment. Seen as a whole, instruments to measure flourishing span multiple domains, to include physical/emotional/spiritual health, positive social relationships, meaning and purpose, character strengths/virtues, competence, self-esteem, autonomy, optimism, resilience, social contribution, and financial security.[134]

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[130] Calhoun L, Tedeschi R. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah, NJ: Lawrence Erlbaum Associates; Ramos, C. & Leal, I. (2012). Posttraumatic growth in the aftermath of trauma: A literature review about related factors and application contexts. *Psychology, Community & Health*, 1(1), 1-20; Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01; Turner den S., Cox, H. (2004). Facilitating post traumatic growth. *Health Qual Life Outcomes*, Jul 13;2:34. doi: 10.1186/1477-7525-2-34. PMID: 15248894; PMCID: PMC481084.

[131] Iswardani, T., Dewi, Z. L., Mansoer, W. W., & Irwanto, I. (2022). Meaning-making among drug addicts during drug addiction recovery from the perspective of the meaning-making model. *Psych*, 4(3), 589-604. https://doi.org/10.3390/psych4030045

[132] Janoff-Bulman, R. (2004). Posttraumatic Growth: Three Explanatory Models. *Psychological Inquiry*, 15(1), 30–34. http://www.jstor.org/stable/20447198

[133] Ogilvie L, Carson J (2025), The G-CHIME model of addiction recovery: an analysis of 20 individual addiction recovery stories. *Advances in Dual Diagnosis*, 18(3), 138–150, doi: https://doi.org/10.1108/ADD-01-2025-0001

[134] Novak, L. F., Fowers, B. J., Kiknadze, N. C., & Calder, A. J. (2024). A close analysis of eight flourishing measures. *The Journal of Positive Psychology*, 20(1), 72–82. https://doi.org/10.1080/17439760.2024.2322468; VanderWeele, T. J. (2017). On the promotion of human

Flourishing in recovery could be thought of as a heightened level of functioning rising from increased attention to body, mind and soul—realms of optimum existence within and across physical health, psychological health, socioeconomic health, and spiritual health. For example, scientific knowledge on the medical and neurobiological dimensions of recovery is growing and informing the degree to which addiction-afflicted damage can be lessened or repaired with sustained recovery time. Such repair spans enhanced brain functioning, resolution of acute medical problems, improved management of chronic disorders, and elevations of other dimension of health, e.g., nutrition, exercise, sleep, and smoking cessation.[135] This research remains limited[136] and has not yet been extended to study of the potential for optimum physical health (flourishing) in recovery, though there are addiction treatment settings that exemplify

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flourishing. Proceedings of the National Academy of Sciences, 114(31), 8148–8156. https://doi.org/10.1073/pnas.1702996114; Weziak-Bialowolska, D., Bialowolski, P., Lee, M. T., Chen, Y., VanderWeele, T. J., McNeely, E. (2021). Psychometric properties of flourishing scales from a comprehensive well-being assessment. *Front Psychol*., Apr 21;12:652209. doi: 10.3389/fpsyg.2021.652209. PMID: 33967913; PMCID: PMC8097094.

[135] Jeynes, K. D. & Gibson, E. L. (2017). The importance of nutrition in aiding recovery from substance use disorders: A review. *Drug and Alcohol Dependence*, 179, 229-239. doi: 10.1016/j.drugalcdep.2017.07.006; Kelly, J. F., Greene, M. C., Bergman, B. G. & Hoeppner, B. (2019). Smoking cessation in the context of recovery from drug and alcohol problems: prevalence, predictors, and cohort effects in a national U.S. sample. *Drug and Alcohol Dependence*, Feb 8;195, 6-12. DOI: 10.1016/j.drugalcdep.2018.11.017; Kelly, J. F., Greene, M. C., & Bergman, B. G. (2018). Beyond abstinence: Changes in indices of quality of life with time in recovery in a nationally representative sample of U.S. adults. *Alcoholism: Clinical & Experimental Research*, 42(4),770-780. DOI: 10.1111/acer.13604; Le Berre, A-P., Fama, R. & Sullivan, E. V. (2017). Executive functions, memory, and social cognitive deficits and recovery in chronic alcoholism: A critical review to inform future research. *Alcoholism Clinical and Experimental Research*, 41(8), 1432-1443; Maillard, A., Poussier, H., Boudehenta,C., Lannuzel, C., Vicente, A. et al. (2020). Short-term neuropsychological recovery in alcohol use disorder: A retrospective clinical study. *Addictive Behaviors*, 105, 106350; Patterson, M. S., Spadine, M. N., Graves Boswell, T., Prochnow, T., Amo, C., Francis, A. N., Russell, A. M., Heinrich, K. M. (2022). Exercise in the treatment of addiction: A systematic literature review. *Health Educ Behav*. Apr 29:10901981221090155. doi: 10.1177/10901981221090155. PMID: 35484950; Staudt, J., Kok, T., de Haan, H. A., Walvoort, S. J. W., & Egger, J. I. M. (2023). Neurocognitive recovery in abstinent patients with alcohol use disorder: A scoping review for associated factors. *Neuropsychiatr Dis Treat*, 19, 2039-2054.

[136] Erickson, C. K. & White, W. L. (2009). The neurobiology of addiction recovery*, Alcoholism Treatment Quarterly*, 27(3), 338 — 345. DOI: 10.1080/07347320903014255. URL: http://dx.doi.org/10.1080/07347320903014255; Humphreys, K. & Bickel, W. K. (2018). Toward a neuroscience of long-term recovery from addiction. *JAMA Psychiatry*, 75(9), 875-876. doi: 10.1001/jamapsychiatry.2018.0956; Nixon, S. J. & Lewis, B. (2020). Brain structure and function in recovery. *Alcohol Res*., Dec 3;40(3):04. doi: 10.35946/arcr.v40.3.04. PMID: 33282611; PMCID: PMC7703868; Parvaz, M. A., Rabin, R. A., Adams, F., Goldstein, R. Z. (2022). Structural and functional brain recovery in individuals with substance use disorders during abstinence: A review of longitudinal neuroimaging studies. *Drug Alcohol Depend*., Mar 1;232:109319. doi: 10.1016/j.drugalcdep.2022.109319. PMID: 35077955; PMCID: PMC8885813.

such a flourishing orientation.[137]. Research on recovery flourishing could flow from the increased interest in lifestyle medicine/psychiatry.[138]

**Dimensions of Character in Recovery Flourishing**

Recovery flourishing domains are closely linked to dimensions of personal character associated with flourishing. The author hesitates to explore traits of character linked to recovery flourishing because such dimensions are more characterizations of conscious aspirations, ongoing processes, and daily practices than fixed traits of personality. That said, higher quality of life and greater social contributions have been linked to certain personal qualities, a number of which are described below.[139] These clusters reflect the dimensions of recovery flourishing observed by the author, described to me, and that are reflected in recovery mutual aid group guidelines for positive living as a person in recovery.[140]

- Guiding Vision / Purpose / Passion / Commitment / Sacrifice / Discipline / Persistence / Patience. Recovery flourishing brings heightened acuity of perception and being—often described as *an awakening*. With newly opened eyes, one sees oneself and one's relationships and world with increasing and often stark clarity. Addiction is reframed as a test—a life chapter that must be completed before one can then draw value and meaning from it. Heightened awareness (consciousness) and clarity of perception, thought, emotion, and action spawn a newfound sense of purpose as well as a commitment to seize unexpected opportunities for growth, even in the most deprived and hostile environments. Daily life is guided by pursuit of goals and challenging tasks, e.g., a highly focused allocation of time, attention, energy, and resources.[141] Flourishing involves assertive time management to maximize time in flow and meaningful activities.

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[137] White, W., Dezhakam, H., Ranjbar, E., Sarapas, C. & Mouton, C. (In Press) Integrating medication and psychosocial support for addiction recovery: A study of Congress 60. *Alcoholism Treatment Quarterly*, DOI:10.1080/07347324.2026.2617255. https://doi.org/10.1080/07347324.2026.2617255.

[138] Deenik, J., Vermeulen, J. M., Teasdale, S. B., Schuch, F. B., Marx, W., Perry. B., Diez G. G., Castellanos. N., et al. (2025). Lifestyle psychiatry: a conceptual framework for application in mental healthcare and support. *BMJ Ment Health*, Nov 25;28(1):e301980. doi: 10.1136/bmjment-2025-301980. PMID: 41290362; PMCID: PMC12658517.

[139] For expanded discussion, see: Kurtz, E. & Ketcham, K. (1992). *The spirituality of imperfection*: Modern wisdom from classic stories. New York: Bantom Books; Kurtz, E. & White, W. (2015). Recovery spirituality. *Religions*, 6, 58–81; doi:10.3390/rel6010058. http://www.mdpi.com/2077-1444/6/1/58. (In Special Issue Religion & Addiction: http://www.mdpi.com/journal/religions/special_issues/religion-addiction.)

[140] Alcoholics Anonymous World Services, Inc. (AAWS, 2019). *Living Sober*. New York, NY; Narcotics Anonymous World Services (NAWS, 2012) *Living Clean*. Vany Nuys, CA; Recovery Dharma Global, Inc. (2023) *Recovery Dharma*. Second Edition. https://drive.google.com/file/d/1Isotp-WlUedFJlKDqjpvO7uKgVsvX3J1/view; White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO.

[141] Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. New York, NY: Harper Perennial.

- Mastery / Competence / Control / Autonomy. People flourishing in recovery have moved beyond the sensation-seeking and impulsivity of active addiction. They have expanded their knowledge and skills to achieve increased control over their lives via active coping in response to both bounty and adversity. Greater autonomy is achieved through conscious control (self-regulation) of biological drives and social pressures. Memory and its meanings are verified, edited, and contextualized. The flourishing person consciously controls his or her thoughts, feelings, and behaviors rather than being controlled by them.[142]
- Authenticity / Genuineness / Integrity / Honesty / Depth / Presence. In flourishing, there is heightened congruence between one's aspirational self and actual self ("walking the walk") and escape from "a world of falsehood and deceit".[143] After peeling off mask after mask (addiction-shaped structures/images/defensive armor), an authentic but incomplete person is revealed ready to be created through one's own efforts. Out of the spiritual crisis of confronting and then shaping a true self comes a state of continual becoming (continual self-improvement).
- Release / Energy / Engagement / Absorption / Vitality / Joy / Humor / Creativity. Asking those in recovery about people in recovery they perceive as flourishing elicits such words as *vitality*, *charisma*, *humor*, and *relishing life*. People flourishing in recovery experience a release from the drug cravings, hustling, manipulation, sense of imposterhood, guilt, and shame that were core dimensions of active addiction. A sense of weightlessness rising from the loss of addiction-inflicted burdens is common as is the experience of an undeserved gift of liberation from entrapment.[144] Humor and laughter—at our own quirkiness and foibles, seeing ourselves in others' experience, and sometimes the sheer ironies and absurdity of it all—seem to be a universal thread in pathways of recovery flourishing. Flourishing brings feelings of awe, and wonder at one's newfound freedom, even in the face of its accompanying complexity of choices and new responsibilities.[145] Flourishing involves not just an increased awareness of choices but experiencing delight in each act of choosing. The meaning in flourishing is found not in attainment of perfection as an accomplishment but in the experience of continual self-creation--the difference between a painting as an object and the experience of painting.

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[142] Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. New York, NY: Harper Perennial.

[143] Vavvos, A., Tzanakis, M., Triliva, S. (2025). "From the world of falsehood to the world of truth": Recovery and reflexivity in Clubs of Families with Alcohol-related Problems in Crete. *J Community Psychol*., Jan;53(1):e22796. doi: 10.1002/jcop.22796. PMID: 35032395.

[144] Scherz, C., Mpanga, G., Namirembe, S. (2022). Not You: Addiction, Relapse, and Release in Uganda. *Cult Med Psychiatry*, Mar;46(1):101-114. doi: 10.1007/s11013-021-09722-9. PMID: 33999310; Snoek, A., McGeer, V., Brandenburg, D., Kennett, J. (2021). Managing shame and guilt in addiction: A path way to recovery. *Addict Behav*, Sep;120:106954. doi: 10.1016/j.addbeh.2021.106954. PMID: 33957551.

[145] Stull, S. W., Wakely, M. E., Saunders, E. C., Jacobson, N. C., Marsch, L. A., Lanza, S. T. (2025). A qualitative study investigating the role of humor in supporting recovery from addiction. *J Subst Use Addict Treat*, Nov 24;181:209833. doi: 10.1016/j.josat.2025.209833. PMID: 41297795.

- Silence / Observation / Listening / Simplicity / Humility / Curiosity / Self-Acceptance (versus vanity/hubris or hopelessness). Recovery flourishing is marked by an acceptance of limitations and making peace with one's imperfections along with a commitment to continual self-inventory and self-improvement, including a willingness to draw from ancestral wisdom and the knowledge and experiences of one's contemporaries.[146]
- Gratitude / Appreciation / Forgiveness (Self and Others) / Tolerance / Openness. These linked traits/acts mark a celebration of survival, delight from having found far more than a solution to a medical illness, and a process of letting go barriers to connection with others.[147]
- Spirituality / Serenity / Being "at home" / Sense of the Sacred / Transcendence. People who are flourishing in recovery possess a clarity of perception and a coherent sense of the world and their place in it. They are comfortable in their own skin and "grounded", as they define them, to land, home, family, and to culture. They exhibit an inner peace that does not preclude activism to improve the state of the world. They have moved beyond the egocentricity (narcissism) of active addiction[148] and sought meaning through relationships and resources beyond the self.[149]
- Harmony / Balance / Inner Tranquility / Integration / Coherence / Wholeness. Individuals who are flourishing in recovery make continual adjustments to keep multiple dimensions of their life in balance. Attention is devoted to domains of life neglected during active addiction. They work to correct addiction-fueled injury to others (past or present acts of omission and commission)—including acts for which no absolution is possible, only self-forgiveness flowing from a profound understanding of addiction.[150] (It is hard enough to preserve innocence through the process of living, impossible through the process of addiction with the "monster/beast/dragon" devouring anything and everyone to sustain its existence.) Human flourishing might well be considered as a process of rising above the potential excess buried within every human appetite.
- Empathy / Compassion / Kindness / Generosity / Love / Service. Flourishing heightens connection, a sense of unity, and service to others as a form of generic

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[146] Ben-Yair, Y., Enright, R. (2025). From poison to medicine: Self-forgiveness as liberation in Jewish faith-based therapeutic communities for addiction recovery in Israel. *J Relig Health*, Oct 3. doi: 10.1007/s10943-025-02470-9. PMID: 41042444.

[147] Lyons, G. C. B., Deane, F. P., & Kelly, P. J. (2010). Forgiveness and purpose in life as spiritual mechanisms of recovery from substance use disorders. *Addiction Research & Theory*, 18(5), 528–543. https://doi.org/10.3109/16066351003660619

[148] "Self-obsession is the core of our disease." Narcotics Anonymous (2008). *Narcotics Anonymous*, Sixth Edition, Narcotics Anonymous World Services, Inc., p. 55.

[149] Carroll, S. (1993). Spirituality and purpose in life in alcoholism recovery. *Journal of Studies on Alcohol*, 54(3), 297–301.

[150] McGaffin, B. J., Lyons, G. C., Deane, F. P. (2013). Self-forgiveness, shame, and guilt in recovery from drug and alcohol problems. *Subst Abus*., 34(4):396-404. doi: 10.1080/08897077.2013.781564. PMID: 24159911; Ohayon, S., Ronel, N. (2025). The moral voice in addiction and the self. *J Subst Use Addict Treat*., Mar;170:209624. doi: 10.1016/j.josat.2025.209624. PMID: 39864557.

restitution and an expression of gratitude for one's own survival. Flourishing imbues a heightened sensitivity to issues of personal and social justice. People flourishing in recovery are known for their generosity of time, talents, and philanthropy (*giving back, paying it forward, carrying the message—we do recover*).

The values implicit within these qualities of the flourishing experience may differ across cultural settings. The dominant traits and practices noted above are for the most part derived from the lives of White, Western, economically secure, heterosexual men in midlife. The meaning of flourishing—its prevalence, domains, qualities, and so forth—will need to be potentially expanded if not redefined as that limitation is overcome. As future research refines this profile, such a profile is likely to become much more nuanced, distinguishing traits common across diverse populations from those that are population specific. For example, spiritual and religious factors, including culturally indigenous methods of healing, have been found to be particularly noteworthy in recovery initiation and maintenance among Black, Indigenous. and people of Color (BIPOC) and to their understanding of the meaning of recovery,[151] but the role of such

[151] Anderson, B. T. & Garcia, A. (2015). 'Spirituality' and 'cultural adaptation' in a Latino mutual aid group for substance misuse and mental health. *BJPsych Bull*., Aug;39(4):191-5. doi: 10.1192/pb.bp.114.048322. PMID: 26755953; PMCID: PMC4706138; Beraldo, L., Gil, F., Ventriglio, A., de Andrade, A. G., da Silva, A. G., Torales, J., Gonçalves, P. D., Bhugra, D., Castaldelli-Maia, J. M. (2019). Spirituality, religiosity and addiction recovery: Current perspectives. *Curr Drug Res Rev*. 11(1):26-32. doi: 10.2174/1874473711666180612075954. PMID: 29895258; Bowser, B. P., Bilal, R. (2001). Drug treatment effectiveness: African-American culture in recovery. *J Psychoactive Drugs*, Oct-Dec;33(4):391-402. doi: 10.1080/02791072.2001.10399924. PMID: 11824698; Garcia, A., Anderson, B., & Humphreys, K. (2015). Fourth and Fifth Step groups: A new and growing self-help organization for underserved Latinos with substance use disorders. *Alcoholism Treatment Quarterly*, 33(2), 235-243; Golan, O., Kresovich, A., Drymon, C., Ducharme, L., Flanagan Balawajder, E., Borowiecki, M., Lamuda, P., Taylor, B., Pollack, H., Schneider, J. (2025). Public perceptions of opioid misuse recovery and related resources in a nationally representative sample of United States adults. *Addiction*, Feb;120(2):253-265. doi: 10.1111/add.16692. PMID: 39428591; PMCID: PMC11710964; Hanson, H. (2005). Isla Evangelista—A story of church and state: Puerto Rico's faith based initiatives in drug treatment. *Culture, Medicine & Psychiatry*, 29(4), 433-456; Heinz, A., Epstein, D. H., Preston, K. L. (2007). Spiritual/Religious experiences and in-treatment outcome in an inner-city program for heroin and cocaine dependence. J Psychoactive Drugs, Mar;39(1):41-9. doi: 10.1080/02791072.2007.10399863. PMID: 17523584; Jordan, A., Costa, M., Nich, C., Swarbrick, M., Babuscio, T., Wyatt, J., O'Connell, M., Guy, K., Blackman, K., Anderson, R. R., Reis, G., Ocasio, L., Crespo. M., Bellamy, C. (2023). Breaking through social determinants of health: Results from a feasibility study of Imani Breakthrough, a community developed substance use intervention for Black and Latinx people. *J Subst Use Addict Treat*., Oct;153:209057. doi: 10.1016/j.josat.2023.209057. PMID: 37207836; Kelly, J. F. & Eddie, D. (2020). The role of spirituality and religiousness in aiding recovery from alcohol and other drug problems: Am investigation in a national U.S. sample. *Psycholog Relig Spiritual*. Feb;12(1):116-123. doi: 10.1037/rel0000295. PMID: 33767804; PMCID: PMC7989793. Kimberly M. (2025). Our recovery in color: The twelve steps for all people of color. Sankofa World Press; Lewis, J. P., Allen, J. (2017). Alaska Native elders in recovery: Linkages between indigenous cultural generativity and sobriety to promote successful aging. *J Cross Cult Gerontol*., Jun;32(2):209-222. doi: 10.1007/s10823-017-9314-8. PMID: 28478599; White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO. Yeung, J. W. K. (2022). Faith-based intervention, change of religiosity, and abstinence of substance addicts. *Braz J Psychiatry*., Jan-Feb;44(1):46-56. doi: 10.1590/1516-4446-2020-1576. PMID: 34190824; PMCID: PMC8827378.

factors in recovery flourishing within these group members has yet to be rigorously investigated.

The above qualities, which constitute antidotes to the corruption of character so common within the addiction experience, can only be fully understood in the context of the journey from addiction to recovery. Addiction reduces person to object (e.g., drug receptacle, mark in a con, a pacified threat); recovery is reclamation of one's humanity and the belief in human possibility. Addiction hollows one out leaving a profound sense of inner emptiness; recovery flourishing is the process of filling such emptiness with new meaning and purpose. The motto of addiction is "I want more"; the motto of recovery flourishing is "I have/am enough."[152] Addiction is a process of physical, psychological, and moral depletion; flourishing in recovery is the fullness achieved through reversal of that process via experiences of unity and completeness. There is in flourishing a sense that the pieces of self that were traded away within the drug relationship are finally retrieved and fit together to become the whole person long searched for.[153]

Addiction thrives on embrace of victimhood and projection of blame, recovery flourishing embraces choice, consent, and responsibility. Addiction reduces one's strategies of coping to that of escape; recovery flourishing involves a broadened repertoire of active coping skills. To flourish is to escape the succoring comfort of seeing the world in black and white to make peace first with shades of grey and to then relish its technicolor qualities. It is a state of joyous curiosity, awe, and wonder at what one does not know but wishes to—embracing a process of perpetual learning that holds what one believes in perpetual probation pending new experience and evidence.

Sustaining addiction demands deception; recovery flourishing is the daily effort to achieve honesty with self and others. The addiction experience is one of suffocating entrapment; recovery flourishing often brings a profound sense of relief and release—a "pink cloud" stage of giddiness in response to one's liberation.[154] Defensive responses to the deterioration of functioning in addiction can include grandiosity and hubris; recovery flourishing instills silent virtues (e.g., humility of achievement). Addiction is fueled by resentment and envy; recovery flourishing is fueled by gratitude and forgiveness of self and others.

Addiction shrinks one's world to the drug-person relationship leaving one isolated and alienated from mainstream culture and one's own people; recovery flourishing involves processes of human connection and intimacy—the replacement of sole

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[152] "Part of our addiction pattern is that we can never get enough." Narcotics Anonymous (2008). *Narcotics Anonymous*, Sixth Edition, Narcotics Anonymous World Services, Inc., p. 80.
[153] Rivaux, S. L., Sohn, S., Armour, M. P., & Bell, H. (2008). Women's early recovery: Managing the dilemma of substance abuse and intimate partner relationships. *Journal of Drug Issues*, 38(4), 957-979. https://doi.org/10.1177/002204260803800402.
[154] Narcotics Anonymous World Services (NAWS, 2012) *Living Clean*. Vany Nuys, CA, p. 80.

dependence on drugs to human interdependence.[155] Addiction is about taking and devouring; recovery flourishing is about the process of service and giving.

People flourishing in addiction recovery are wounded, imperfect people doing their best to heal and do good—often in imperfect circumstances. They recognize that they are not a finished product but a creation of their own making—sculptors in whose hands their futures rest despite whatever limitations the universe imposes. Within this process, these "wounded healers" have discovered meaning far beyond their escape from addiction. While such flourishing qualities may be hard to describe, those who possess them often become role models (e.g., *recovery carriers, elders*) exerting a contagious effect on others seeking a way out of addiction and related problems.[156] Their evangelical zeal conveys not THE pathway of recovery but celebration of recovery by any means necessary under any circumstances. The person who sustains recovery flourishing for years has achieved a credential that no university can bestow—vetting by a community of people who have witnessed and perpetrated every manner of hustle to survive. To be vetted with admiration and trust from such a community is an exceptional gift that can be received but only sought from a position of humility.

> *What I try to do is be an example—to be an attraction rather than a promotion. I want there to be something about my character that when you meet me, you would say, "This is a decent person. There's something about his spirit. Ther's somethi9ng about when I look in his eyes. There is something about him that makes me want to ask him more about what he draws from*.[157]

Some approaches to recovery suggest the need for acceptance of the character mutations (imperfections) that are a common consequence of the addiction experience.[158] Others suggest that recovery involves processes of destruction and construction—that manifestations of the addictive self (its emotional and behavioral remnants) must be expunged to create the space in which the elements described above can be constructed. What the above flourishing descriptors share is the

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[155] Hart, K. E., & Singh, T. (2009). An existential model of flourishing subsequent to treatment for addiction: The importance of living a meaningful and spiritual life. *Illness, Crisis & Loss*, 17(2), 125-147. https://doi.org/10.2190/IL.17.2.d; McGee, M. D. (2020). Awakening and recovery. *Alcoholism Treatment Quarterly*, 38(2), 266–285. https://doi.org/10.1080/07347324.2019.1632766

[156] Momper, S. L., Dennis, M. K., Mueller-Williams, A. C. (2017). American Indian elders share personal stories of alcohol use with younger tribal members. *J Ethn Subst Abuse*, Jul-Sep;16(3) , 293-313. doi: 10.1080/15332640.2016.1196633. PMID: 27403635; PMCID: PMC6088812; Skewes, M.C. & Lewis, J. P. (2016). Sobriety and alcohol use among rural Alaska Native elders. *International Journal of Circumpolar Health*, 75, 30476.; White, W. & Best, D. (2026a) Social contagion and addiction recovery. Unpublished Paper.

[157] Bilal Ameen, quoted in Kimberly M. *Our recovery in color: The twelve steps for all people of color*, Sankofa World Press, 134-135.

[158] White, W. (2012). The history of Secular Organizations for Sobriety—Save Our Selves: An interview with James Christopher. Accessed February 15, 2026 at https://deriu82xba14l.cloudfront.net/file/1569/James%20Christopher%20Interview%202012.pdf

replacement of primitive desires/needs with new principles and skills as the driving force of daily decision-making.

That said, flourishing often involves embrace of complexity and contradiction—the ability to both value one's current beliefs while simultaneously questioning them. This sometimes involves entertaining opposing ideas that lead to new and more nuanced understandings and embrace of some of the paradoxes of recovery flourishing. Flourishing is at once an act of self-submission and self-assertion ("Easy does it but do it!") with the emphasis on each varying across philosophies of addiction recovery.[159] Within philosophies that embrace a "spirituality of not having all the answers", the first person to step forward to exemplify recovery and recovery flourishing is, by that act of hubris, the least qualified to represent the flourishing experience. As Kurtz observed in his history of AA, "A.A.'s Steps and Traditions combine with the fellowship's practice of anonymity to issue an ironic reality: those who best practice them speak least dogmatically about them."[160]

Seen as a whole, the above qualities suggest that flourishing is a state of transcendence—a rehabilitation that extends beyond bodily repair to encompass recovery protection and transformation of personal character (who one is) and actions (what one does in the world).[161] Such an expansive understanding blends the concept of flourishing into other related concepts, e.g., post traumatic growth, well-being, quality of life, etc. Cook, for example, identified thirteen conceptual components of spirituality related to addiction recovery, many of which overlap with flourishing qualities noted above (e.g., connection, transcendence, meaning and purpose, authenticity, wholeness, heightened awareness).[162] White similarly defined spirituality in the context of addiction recovery as "a heightened state of perception, awareness, performance or being that personally informs, heals, empowers, connects, centers or liberates"—elements that again overlap with dimensions of recovery flourishing.[163] Such conceptual overlap affirms earlier noted complexities related to the definition, measurement, and mapping of recovery flourishing and related experiences. The clusters of character described above also reflect values and principles of diverse recovery mutual aid organizations, though the degree of emphasis on each may vary from group to group.[164]

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[159] Tsutsumi, S. (2025). Philosophical diversity in 12-Step and alternative mutual help groups for alcohol use disorder: Understanding recovery through the reflexive self in late modernity. *Alcoholism Treatment Quarterly*, 43(4), 630–641. https://doi.org/10.1080/07347324.2025.2528752

[160] Kurtz, E. (1979). *Not-God: A history of Alcoholics Anonymous*. Hazelden, p. 260 .

[161] Koh, H. K., Frederick, D. E., Balboni, T. A, et al. (2026). Spirituality and harmful or hazardous alcohol and other drug use: A meta-analysis of longitudinal studies. *JAMA Psychiatry*. Published online February 18, 2026. doi:10.1001/jamapsychiatry.2025.4816

[162] Cook, C. C. H. (2004). Addiction and spirituality. *Addiction*, 99, 539-551.

[163] White, W. (1992). Spirituality: Its language and boundaries. In Spirituality and prevention (pp. 37-47). Springfield, IL: Illinois Prevention Resource Center. Posted at https://deriu82xba14l.cloudfront.net/file/471/1992-Spirituality-Essay.pdf

[164] Alcoholics Victorious Headquarters (2025). Frequently Asked Questions, accessed December 31, 2025 at https://www.alcoholicsvictorious.org/faq#recovery; Cocaine Anonymous World Services, Inc. (CAWS, 2025) 12 Principles. Accessed December 29, 2025 at https://share.google/Sel68qnxYpC3kT1B6;

**Recovery Flourishing as the Outcome of Existential/Spiritual Crisis**

Addiction involves Sisyphean cycles of consuming a drug that induces suffering and whose only relief is continued consumption of the drug that has become both perpetrator and rescuer. The sense of futility and meaninglessness arising from the unceasing repetition of this pattern triggers existential despair that can open a doorway to change or plunge one deeper into the search for oblivion. For flourishing to occur within the recovery experience, the defensive structures that sustained addiction and prevented objective self-observation must collapse. In the aftermath of such collapse comes the terrifying awareness that one has survived a prolonged game of Russian roulette, that one is beyond lucky to be alive. It is this state of heightened awareness that as Dr. Jean Kirkpatrick has described "…growth is essential or else sobriety will feel like a deprivation".[165] It is in such a state that one must answer anew existential questions that were acted out destructively within the addiction experience—questions whose answers will become the building blocks of recovery and flourishing.

Where and from whom did I come (ancestral history)? Why did I survive when others did not (survival guilt)? Who am I and how did I become the person I am today (identity and life/addiction/recovery story)? Was my suffering deserved (a consequence of my own choices) or undeserved (a consequence of vulnerabilities and processes over which I had minimal if any control) or both (a collision of vulnerability and culpability)? Am I a victim, volunteer, or villain (or all three)? Who are "my people" (family/tribe)? Where do I feel "at home"—safe and most rooted (place, land)? Given my residual brain fog, how do I know what is real and true (metaphysics/epistemology)? What do I most cherish (character, values)? What standards/rules will now guide my relationships with others (ethics)? What actions/experiences uplift my spirit and imbue a sense of beauty, awe, and wonder (aesthetics)? When am I totally engaged (flow)? When do I feel most alive (awareness / presence), and what gives me the deepest pleasure and meaning (bliss)? How can I repay the debts I have incurred (justice)? Who do I most admire and want to model myself after (heroes)? What must I be and do to have a good life (virtue)? What must I do today to preserve, protect, and extend what I most value (daily duties/practices)? What is the nature of existence and my purpose within it (worldview, mission)?

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Kirkpatrik, J. (2025). Women for Sobriety New Life Program. Women for Sobriety, Quakertown, PA.; Kirkpatrick, J. (2025). The Hungering Heart.Accessed December 29, 2025 at https://womenforsobriety.org/wp-content/uploads/2023/05/The-Hungering-Heart.pdf; Kuplinski, R. (2025). Definition of the values of SMART Recovery. Accessed December 30, 2025 at https://smartrecovery.org/blog/defining-the-values-of-a-smart-meeting; LifeRing Secular Recovery (2025). Recovery Toolbox. Accessed December 31, 2025 at https://lifering.org/lifering-resources/recovery-toolbox/; Narcotics Anonymous World Services (NAWS, 2012) *Living Clean*. Vany Nuys, CA; Recovery Dharma Global, Inc. (2023) Recovery Dharma. Second Edition. https://drive.google.com/file/d/1Isotp-WlUedFJlKDqjpvO7uKgVsvX3J1/view; Women for Sobriety (WFS, 2025). Levels of recovery. Accessed December 14, 2025 at https://womenforsobriety.org/new-life-program/levels-of-recovery/; White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO.

[165] Kirkpatrik, J. (2025). Women for Sobriety New Life Program. Women for Sobriety, Quakertown, PA., p. 20.

After diverse experiments to answer such questions during addiction and early recovery, many are left in a state of disillusionment and discontent asking, “Is there more to life than this?” and “Having survived, what am I going to do with the time I have been gifted?” Dunkel and colleagues refer to such questions as the “exploration of possible selves”[166]—questions most people face at some point in their lives. What adds urgency to them for people in recovery is a heightened awareness of survival, release, and expanded possibilities.

Answering such questions address what Victor Frankl referred to as the ultimate human need—the thirst for meaning.[167] There are religious, spiritual, and secular pathways and patchworks of meaning within the experience of recovery flourishing.[168] Across these pathways, there is a rigorous interrogation of the meaning of life that transcends superficial obedience to prepackaged answers. While those in recovery represent a broad spectrum of religious orientations, it is impossible in listening to those thriving in recovery not to hear echoes of Zen Buddhism, humanism, existentialism, stoicism, and pragmatism even from those who have no formal knowledge of such philosophies and practices. Answers to such existential questions may be superficial and fleeting in early recovery but later take on greater clarity and depth within the experience of recovery flourishing.

The utter isolation of addiction (toxic self-absorption) and the life, death, and rebirth dimensions of addiction recovery force such questions into acute awareness and open a doorway into a heightened experience of living.[169] Flourishing can be experienced as an intensification of perception, thought, feeling, and action or a peaceful and profound realization that one is enough, has enough, has done enough, and in this moment is complete (flawed and imperfect but whole). Addiction is a narrowing and hollowing out process that strips life of meaning beyond the unceasing drug pursuit, leaving in its wake a loss of meaning and existential vacuum. Recovery thus becomes a process of broadening and refilling one’s life with meaningful thought, emotion, action, and relationships. Flourishing is the resulting sense of fullness

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[166] Dunkel, C. S., Kelts, D., & Coon, B. (2006). Possible selves as mechanisms of change in therapy. *Possible selves: Theory, research and applications*, 187-204; also see Kemp, R. (2019). Addiction and addiction recovery: a qualitative research viewpoint. *Journal of Psychological Therapies,* 4(2), 167–179.

[167] Frankl, V. E. (1963). *Man's Search for Meaning*. Pocket Books.

[168] Kurtz, E. & White, W. (2015). Recovery spirituality. *Religions, 6,* 58–81; doi:10.3390/rel6010058. http://www.mdpi.com/2077-1444/6/1/58. (In Special Issue Religion & Addiction: http://www.mdpi.com/journal/religions/special_issues/religion-addiction.); Lovett, K. L., Weisz, C. (2021). Religion and recovery among individuals experiencing homelessness. *J Relig Health*, Dec;60(6):3949-3966. doi: 10.1007/s10943-020-01060-1. PMID: 32654014.

[169] Krowka, J., Aller, L. (2025). Recovery from heroin addiction: A qualitative study. *Public Health Nurs*., Mar-Apr;42(2):744-753. doi: 10.1111/phn.13526. PMID: 39740126; PMCID: PMC11895412; Monteiro, V., Bloc, L., Messas, G. (2024). What is it like to be in alcohol addiction recovery? A dialectical phenomenological analysis. *Psychopathology*., 57(5):377-388. doi: 10.1159/000538267. PMID: 38754403; Wojtkowiak, J., Vanherf, N. C., Schuhmann, C. M. (2019). Grief in a biography of losses: Meaning-making in hard drug users' grief narratives on drug-related death. *Death Stud*., 43(2):122-132. doi: 10.1080/07481187.2018.1456708. PMID: 30252614.

experienced as both a reward for one's personal effort and as an undeserved gift that could be lost without continued vigilance and self-care.

**Recovery Flourishing as an Act of Rebellion**

> *The only way to deal with an unfree world is to become so absolutely free that your very existence is an act of rebellion*. –Albert Camus

As earlier noted, flourishing within the experience of addiction recovery can reflect diverse pathways and styles. Some may seek to flourish by achieving accommodation within existing social structures and their imposed expectations (flourishing as an achievement of conformity and normality—making peace with the world as it is) while others may challenge such structures and expectations (flourishing as an act of rebellion).[170] The latter claims not just the right to flourish, but to subjectively define the very meaning and context of flourishing within one's unique historical and life circumstances.

To suggest that recovery and recovery flourishing can constitute acts of rebellion raises the question, "Precisely what and who is the target of such rebellion?" There are at least three potential answers to that question representing different styles of rebellion: 1) recovery flourishing as an act of defiant vengeance in response to doubters and predictors of one's ultimate failure and early death, 2) recovery initiation and flourishing as a battle against the addiction "monster/beast/dragon", and 3) recovery and recovery flourishing as acts of resistance against a predatory addiction industrial complex and the larger structures and machinery of oppression of which it is an integral component.

Flourishing as Revenge. For some people in recovery, the rebel role is an extension of the 'black sheep', misfit, outcast, outsider, outlaw role long thrust on them and too often self-embraced[171] and further indicated by past resistance to treatment and recovery as acts of rebellion[172]. The choice is to then live out such a prescribed script or author an anti-script. It is possible to embrace rather than denunciate the rebel identity as a dimension of one's recovery experience. This takes what has been a historical burden (the role of misfit, outcast, outsider) and transforms it into something positive—character development through defiance, resistance and activism. The latter elicits a style of resistance in which the addicted person embarks on a recovery journey and post-recovery achievement as a defiant "I'll show all of you". Such a stubborn refusal to self-destruct may not represent an ideal source of motivation but it can propel one into recovery and a life enrichment process that suffices until other more sustainable

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[170] Chang, J. (2021). Women who use drugs: Resistance and resistance and rebellion. In: the impact of global drug policy on women. In *The impact of global drug policy on women: Shifting the needle* edited by Julia Buxton, Givana Margo, and Lona Burger, pp. 271-286.
[171] DiClemente, C. C. (2013). Paths through addiction and recovery: The impact of spirituality and religion. *Substance Use & Misuse*, 48(12), 1260–1261. doi:10.3109/10826084.2013.808475
[172] Dennis, F., & Pienaar, K. (2023). Refusing recovery, living a 'wayward life': A feminist analysis of women's drug use. *The Sociological Review*, 71(4), 781-800. https://doi.org/10.1177/00380261231175729

motivations arrive within the processes of change. The primary risk with this style of rebellion is that one seeks what will be viewed as achievement in the eyes of others and not what would provide one's own deepest meaning

Flourishing as an Argument (Living Proof). Forging a flourishing life in recovery is itself an act of rebellion—a living refutation of the proposition "once an addict, always an addict" and a refutation of the low bar of expectations so often imposed on people in recovery and members of other oppressed communities.[173] In the recovery history in the U.S., this rebel role has been carried into the recovery process and has even led to alternatives to mainstream 12-Step recovery support groups via Charles Dederich (Synanon), Dr. Jean Krikpatrick (Women for Sobriety), James Christopher (Secular Organizations for Sobriety), James Baker (Celebrate Recovery), and other recovery mutual aid organizational leaders.[174]

This second style of rebellion is based on recognition that addiction, as the monster/dragon it is often conceived as, eats away the self. There is a tipping point of protest accompanying this awareness when one declares, "Enough! The remaining parts of me you will not take ". This is the point of rebellion, the euphemistic "bottom," where one finally rises to "slay the dragon." This tipping point of "No more!" is the act of defiance in which the addicted self (the slave) says "No!" to the master and "Yes!" to the promise of a new liberated self. This style of rebellion can also be a rejection of the forces of intergenerational addiction and related problems (e.g., poverty, mental illness, incarceration)—a breaking of the chain.

> *To walk the Red Road is to offer a silent proclamation: Here the destruction stops. We will heal ourselves, we will heal our wounded relationships, we will heal our children, we will heal our nation. On this day, our future history begins*.—*The Red Road to Wellbriety*.[175]

Some mothers in recovery, for example, exhibit this style via overcompensation of parental recovery engagement as a refutation of the "addicted mother as monster" trope.[176] In response to skepticism about one's prospects of recovery, it is an unequivocal declaration of dissent expressed through the quality of one's life in recovery.

Flourishing as Protest. Such rebellion is often fueled by heightened awareness of larger contextual influences on addiction and recovery. The intent is the replacement of

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[173] While AA and NA embrace lifelong addiction risk (an understanding of *sober alcoholic* and *clean addict*), public meaning of "addict" continues to be a person presently using and addicted to alcohol or other drugs. Rebellion in recovery in this contact is a rejection of that public conception. (See Kurtz, E. (1979). *Not-God: A history of Alcoholics Anonymous*. Hazelden.

[174] White, W. (1998/2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Chestnut Health Systems.

[175] White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO.

[176] Gueta, K., & Addad, M. (2013). Moulding an emancipatory discourse: How mothers recovering from addiction build their own discourse. *Addiction Research & Theory*, 21(1), 33–42. https://doi.org/10.3109/16066359.2012.680080

high-risk with high resistance in future generations.[177] This is achieved by neutralizing the effects of risk factors (e.g., historical trauma, family history of drug-related problems, adverse childhood experiences) with resiliency factors (positive parenting, consistent family meal and bedtime rituals, peer social support, organized activities, access to community resources).[178] Caroline Beidler has described how this style of rebellion can be catalyzed by efforts to break family addiction traditions and norms.

> *It is a common experience for people to get into recovery and that recovery is experienced by the family as a rejection of addiction grounded norms. Black sheep recovery rebels against normed pathology*.[179]

This third style of rebellion also can involve breakthroughs of perception about the nature of the world and one's role in it. More specifically, it is recognition that one has, through one's addiction, unconsciously participated in one's own oppression and the oppression of one's people. It is a vow to recover as an act of defiance against such oppression via embrace of the role of advocate or activist. Flourishing among historically marginalized populations as an act of protest rests on recognition that such groups face increased addiction vulnerability and enhanced obstacles to recovery initiation, recovery maintenance, and quality of life within the recovery experience.[180] As described by Mark Sanders, "Flourishing of self becomes an act of love for one's culture flowing from what Dr. Martin Luther King, Jr. called a sense of somebody-ness."[181]

Recovery initiation and recovery flourishing as acts of resistance and rebellion within oppressed communities rest on several propositions drawn from the collective experience of the indigenous peoples of Africa, Australia, Canada, Hawaii, New

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[177] Vanyukov, M. M., Maes, H. H. M., Iacono, W. G., Kirisci, L., Samek, D. R., Silberg, J. L., Zimmerman. E. B., Prom-Wormley. E. C. (2023). The concept of resistance to substance use and a research approach: The Resist! Project. *Twin Res Hum Genet*., Feb;26(1):31-39. doi: 10.1017/thg.2023.8. PMID: 36896815; PMCID: PMC10363246.

[178] Aschengrau, A., Winter, M. R., Shea, M. G. (2023). Association between resilience promotion factors during childhood and risk of drug use disorder during adulthood. *Addict Subst Abus* (Middlet), 2(1):1-10. doi: 10.46439/addiction.2.007. PMID: 37427318; PMCID: PMC10326717; Wolin, S. J., Bennett, 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(3), 199-214.

[179] Stauffer, B. & Beidler, C. (2026). An Interview with Caroline Beidler – The Future of Family Recovery as a Coproduced Collaborative Process of Resiliency: The Frontiers of Recovery Research Interview Series – Recovery Review, Accessed February 25, 2026.

[180] Bommersbach, T. J., Jegede, O., Stefanovics, E. A., Rhee, T. G., Rosenheck, R. A. (2022). Diagnostic remission of substance use disorders: Racial differences and correlates of remission in a nationally representative sample. *J Subst Abuse Treat*. May;136:108659. doi: 10.1016/j.jsat.2021.108659. PMID: 34785084; Pouille, A., Bellaert, L., Vander Laenen, F., Vanderplasschen, W. (2021). Recovery capital among migrants and ethnic minorities in recovery from problem substance use: An analysis of lived experiences. *Int J Environ Res Public Health*., Dec 10;18(24):13025. doi: 10.3390/ijerph182413025. PMID: 34948635; PMCID: PMC8700971; Pouille, A., De Kock, C., Vander Laenen, F., Vanderplasschen, W. (2022). Recovery capital among migrants and ethnic minorities: A qualitative systematic review of first-person perspectives. *J Ethn Subst Abuse*, Jul-Sep;21(3):845-875. doi: 10.1080/15332640.2020.1836698. PMID: 33135965.

[181] Sanders, M. (2026). Personal communication, January 26, 2026.

Zealand, and the United States but are also applicable with some variations to other historically exploited and disempowered people (e.g., people of color, women, LGBTQ+, migrants, or economically disadvantaged white communities).[182] Such propositions include the following.

1. Culturally ritualized use of psychoactive drugs (including fermented alcohol) existed within traditional indigenous religious and medical practices prior to European colonization.[183] Such cultural controls prevented addiction as it is known today. Drug-related problems within Native communities were also minimal during the period of initial introduction of distilled alcohol by Europeans.[184]
2. Alcohol and other drugs were historically used, and continue to be used, as weapons of political, economic, and sexual exploitation and cultural subjugation within the larger processes of colonization.[185]
3. Alcohol and other drug problems within indigenous communities rose in tandem with the loss of cultural institutions, traditions, and ceremonies following

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[182] Dertadian, G. C. (2024). The Coloniality of drug prohibition. *Int J Drug Policy*, Apr;126:104368. doi: 10.1016/j.drugpo.2024.104368. PMID: 38452423; 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.; Helmer, J. (1975). *Drugs and minority oppression*. Seabury Press; Williams, I. L., Makini, G. K., & Rezentes, W. C. (2021). Indigenous Hawaiian psychoactive drug use: Before European contact, and after 1778. *Journal of Psychoactive Drugs*, 53(2), 111–126. https://doi.org/10.1080/02791072.2020.1833114 .

[183] Abbott. P. J. (1996). American Indian and Alaska native aboriginal use of alcohol in the United States. *Am Indian Alsk Nativ Ment Health Res* (1987), 7(2):1-13. doi: 10.5820/aian.0702.1996.1. PMID: 8935245; D'Abbs, P. & Hewlett, M. (2023). *Learning from 50 years of Aboriginal alcohol programs*. Springer; Matamonasa-Bennet, A. (2017). "The poison that ruined the nation": Native American men—Alcohol, identity, and traditional healing. *American Journal of Men's Health*, 11(4), 1142-1154; Seale, J. P., Shellenberger, S., Spence, J. (2006). Alcohol problems among Alaska Natives: lessons from the Inuit. *Am Indian Alsk Native Ment Health Res*., 13, 131; Williams, I. L., Makini, G. K., & Rezentes, W. C. (2021). Indigenous Hawaiian psychoactive drug use: Before European contact, and after 1778. *Journal of Psychoactive Drugs*, 53(2), 111–126. https://doi.org/10.1080/02791072.2020.1833114.

[184] Mancall, P. C., Robertson, P., Huriwai, T. (2000). Maori and alcohol: A reconsidered history. *Australian & New Zealand Journal of Psychiatry*, 34(1), 129-134. doi:10.1046/j.1440-1614.2000.00693.x; 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.

[185] 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.; Blyton, G. (2013). Rum and corn pipes: The introduction of alcohol and tobacco into Aboriginal populations of the Hunter Region of central eastern New South Wales, Australia, in the first half of the 19th century. *AlterNative: An International Journal of Indigenous Peoples*, 9(4), 296-308. https://doi.org/10.1177/117718011300900402; de Oliveira, R. C., Nicolau, B. F., Levine, A., Mendonça, A. V. M., Videira, V., Vargas, A. M. D., Ferreira, E. F. E. (2019). "When a Tihik drinks kaxmuk he neither has a father, nor a mother, or a brother": perceptions of Maxakali on the effects of sugarcane liquor consumption. *Cien Saude Colet*., Aug 5;24(8):2883-2894. Portuguese, English. doi: 10.1590/1413-81232018248.16992017. PMID: 31389536; Gluckman L. K. (1974). Alcohol and the Māori in historic perspective. *New Zealand Medical Journal*, 79: 553–555; Mancall, P. C., Robertson, P., Huriwai, T. (2000). Maori and alcohol: A reconsidered history. Australian & New Zealand Journal of Psychiatry, 34(1), 129-134. doi:10.1046/j.1440-1614.2000.00693.x; Mcdowell, T. (2015). Taua Nākahi Nui: Māori, liquor and land loss in the 19th century. *AlterNative: An International Journal of Indigenous Peoples*, 11(2), 103-117. https://doi.org/10.1177/117718011501100202; Unrau, W. E. (1996). *White Man's wicked water: The alcohol trade and prohibition in Indian Country, 1802-1892*. University Press of Kansas.

genocidal wars, mass deaths from epidemic disease (e.g., smallpox, measles), loss of ancestral lands and means of sustenance, forced removal of Native children, criminalization of cultural ceremonies, and coerced efforts of assimilation.[186]

4. Historical and contemporary trauma (colonization/oppression) inflicted intergenerational injuries that heightened vulnerability for community-wide self-medication, high addiction prevalence, and related problems.[187] The devil dangled a soothing elixir for personal and communal pain that was in reality a "false refuge" and a personal/cultural poison. In this case, the devil turns out not to be an evil mythical figure, but a confluence of exploitive political, social, economic, and religious interests and institutions. The greatest injury involved and still involves rendering people accomplices in their own destruction and engendering self-blame.[188]
5. Alcohol and other drug use within Indigenous and minoritized communities serves multiple functions: self-medication of grief, powerlessness, and emotional pain; defiance/protest against oppression and marginalization; an affirmation of cultural (e.g., Indian) identity, acting out stigma (inferiority) scripts, and hunger for group cohesion.
6. High addiction prevalence and related problems within minority communities are fabricated, exaggerated, and decontextualized while ignoring high variability of alcohol use across communities as well as high rates of abstinence and problem resolution.[189] Such distortions are used by dominant political and cultural leaders

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[186] 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; Mancall, P. C., Robertson, P., Huriwai, T. (2000). Maori and alcohol: A reconsidered history. *Australian & New Zealand Journal of Psychiatry*, 34(1), 129-134. doi:10.1046/j.1440-1614.2000.00693.x; Nutton, J., & Fast, E. (2015). Historical trauma, substance use, and indigenous peoples: Seven generations of harm from a "big event." *Substance Use & Misuse*, 50(7), 839–847. https://doi.org/10.3109/10826084.2015.1018755; Williams, I. L., Makini, G. K., & Rezentes, W. C. (2021). Indigenous Hawaiian psychoactive drug use: Before European contact, and after 1778. *Journal of Psychoactive Drugs*, 53(2), 111–126. https://doi.org/10.1080/02791072.2020.1833114

[187] Brave Heart, M.Y., Chase, J., Ellkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous people of the Americans: Concepts, research, clinical considerations. *Journal of Psychoactive Drugs*, 43(4), 282-290; Ehrmin, J. T. (2002). "That feeling of not feeling": Numbing the pain for substance-dependent African American women. *Qualitative Health Research*, 12(6), 780-791; Herron, J. L., Venner, K. L. (2023). A systematic review of trauma and substance use in American Indian and Alaska Native individuals: Incorporating cultural considerations. *J Racial Ethn Health Disparities*, Apr;10(2):603-632. doi: 10.1007/s40615-022-01250-5. PMID: 35089579; PMCID: PMC9329482; Nutton, J., & Fast, E. (2015). Historical trauma, substance use, and indigenous peoples: Seven generations of harm from a "big event." *Substance Use & Misuse*, 50(7), 839–847. https://doi.org/10.3109/10826084.2015.1018755.

[188] Gonzalez, V. M. & Skewes, M. C. (2018). Association of belief in the "firewater myth" with strategies to avoid alcohol consequences among American Indian and Alaska Native college students who drink. *Psychol Addict Behav*, 32(4), 401-409; Gonzalez, V. M. & Skewes, M. C. (2021). Belief in the myth of an American Indian/Alaska Native biological vulnerability to alcohol problems among reservation-dwelling participants with a substance use problem. *Alcohol Clin Exp Res*, 45(11), 2309-2321; Groves, P., & Farmer, R. (1994). Buddhism and addictions. *Addiction Research*, 2(2), 183–194. https://doi.org/10.3109/16066359409109142.

[189] Gilder, D. A., Lau, P., Corey, L., & Ehlers, C. L. (2008). Factors associated with remission from alcohol dependence in an American Indian community group. *The American Journal of Psychiatry*, 165(9), 1172–1178. https://doi.org/10.1176/appi.ajp.2008.07081308; Leung, P. K., Kinzie, J. D., Boehnlein, J. K., Shore,

to bolster theories of biological and cultural inferiority, e.g., theories of biological vulnerability (e.g., “firewater myths”[190]) or racial/cultural psychopathy (e.g., Black criminality, super predator caricatures/tropes) rather than a behavioral product of systemic factors (i.e. a predictable outcome of intergenerational trauma and oppression).[191]

7. Regulatory designation of psychoactive drugs as celebrated, tolerated, instrumental, or prohibited (and related punishments) are determined by their proximity or distance to those possessing historical power, e.g., their proximity to affluent whiteness.[192] Marginalized populations are associated with the prohibited drug; blamed for problems of drug-related crime, violence, insanity and the moral corruption of youth; and cast not as just “less than” but as “bad people” who pose an existential threat to the future of “good people” and who thus must be suppressed or eliminated.[193]
8. “External efforts by the colonizer to suppress or control drug availability imbues the drug with meaning as a symbol of cultural protest and sets up acts of defiant self-destruction” within marginalized communities (Coyhis & White, 2006).
9. The machinery of oppression includes passive and active infusion of psychoactive drugs into minority communities as a tool of subjugation, control, and profit.
10. Limited economic opportunities assure marginalized population complicity in the illicit underground drug economy and provide a rationale for hyperaggressive surveillance and policing of the minority community and their related consequences (e.g., disproportionate rates of arrest, death in custody, harsh sentencing, mass incarceration, and removal of minority children from family/community).

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J. H. (1993). A prospective study of the natural course of alcoholism in a Native American village. *J Stud Alcohol.*, Nov;54(6):733-8. doi: 10.15288/jsa.1993.54.733. PMID: 8271810; Skewes, M.C. & Lewis, J. P. (2016). Sobriety and alcohol use among rural Alaska Native elders. *International Journal of Circumpolar Health*, 75, 30476; Spicer P. (2001). Culture and the restoration of self among former American Indian drinkers. *Soc Sci Med*., 53, 22740; Venner, K. L., Hagler, K., Cloud, V., Greenfield, B. (2019). Native Americans resolve alcohol use disorder: "Whatever it takes or all that it takes". *Cultur Divers Ethnic Minor Psychol*., Jul;25(3):350-358. doi: 10.1037/cdp0000241. PMID: 30570290.

[190] Coyhis, D. L., & White, W. L. (2006*). Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. White Bison, Inc.; Leland J. (1976). *Firewater myths: North American Indian drinking and alcohol addiction*. Rutgers Centre of Alcohol Studies, 1976.

[191] Rowe, D., & Grills, C. (1993). African-centered drug treatment: An alternative conceptual paradigm for drug counseling with African-American clients. *Journal of Psychoactive Drugs*, 25(1), 21–33. https://doi.org/10.1080/02791072.1993.10472588

[192] Dertadian, G. C. (2024). The Coloniality of drug prohibition. *Int J Drug Policy*, Apr;126:104368. doi: 10.1016/j.drugpo.2024.104368. PMID: 38452423.

[193] 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.; Helmer, J. (1975). *Drugs and minority oppression.* Seabury Press; White, W. (1979). Themes in chemical prohibition. In Drugs in perspective. National Drug Abuse Center/National Institute on Drug Abuse. Posted at https://deriu82xba14l.cloudfront.net/file/26/1979-Themes-in-Chemical-Prohibition.pdf.

11. “The problems arising within colonized peoples are defined as unresolvable within these communities and solvable only through the patronage of the dominant culture”.[194]
12. Marginalized communities (e.g., drug using and addicted people of color and poor whites) then become the raw materials to feed majority institutional economies and power, e.g., police, courts, jails/prisons, probation/parole, child welfare, public assistance, addiction treatment, etc.[195] An addiction industrial complex (the total drug supply and demand reduction apparatus) enhances the power and profit of majority individuals and institutions while constricted opportunities feed illicit underground economies that drain minority community resources.[196]
13. Drug-affected minority communities are provided with limited access to prevention, harm reduction, early intervention, treatment, and recovery support services compared to those provided in majority communities.
14. Treatment services that are provided often reflect low expectations that are too often a setup for failure rather than flourishing. Models of care are ill-suited to the needs of people of color—models that by focusing on short-term intrapersonal symptom suppression rather than support for long term recovery and recovery flourishing create a revolving door that feeds dependency, helplessness and hopelessness and ignores the social conditions in which addiction spreads and is sustained.[197]
15. Culturally indigenous pathways of recovery and aids to recovery (e.g., indigenous history and methods of healing) are suppressed (discouraged, stigmatized, prohibited) by the dominant culture and replaced with culturally dominant beliefs and technologies. Minority bodies become subjects of medical experimentation that benefit the majority community.[198]
16. “Indigenous movements emerge that provide a solution to drug-related problems (and other health and social problems) through processes of personal purification and cultural renewal”[199]—the latter often involving enhanced cultural identification and embrace of cultural values, traditions, and healing practices (e.g., medicine

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[194] Coyhis, D. L., & White, W. L. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. White Bison, Inc.; Greywolf, C. T., & Lowe, J. R. (2022). Colonization and the introduction of alcohol to Native Hawaiians: Why cultural safety. *Journal of Indigenous Research, 10,* 7; Greywolf, C. T., Palakiko, D. M., Pokhrel, P., Vandewater, E. A., Kataoka-Yahiro, M., Casken, J. (2025). Exploring a shared history of colonization, Historical trauma, and links to alcohol use with Native Hawaiians: Qualitative Study. Asian Pac Isl Nurs J., 9 e68106.

[195] Dollar, C. B. (2018). Criminalizatioon and drug ‘wars’ or medicalization and health ‘epidemics’: How race, class, and neoliberal politics influence drug laws. *Critical Criminology*, doi:10.1007/g10612 9308 7.

[196] Davis, A. (1997). Angela Davis Frontline Interview, www.pbs.org. 1997. Accessed at https://www.azquotes.com/author/3699-Angela_Davis?p=2

[197] 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.

[198] Washington, H. A. (2008). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. Vintage.

[199] Coyhis, D. L., & White, W. L. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. White Bison, Inc.

wheel, sweat lodge, talking circles, traditional healing methods).[200] Recovery and criminal desistance conveyed through redemptive storytelling are framed as acts of personal/cultural survival/healing/sovereignty/revitalization.[201]

17. Progress achieved through recovery-focused cultural revitalization movements is challenged by backlash from the mainstream culture that seek to restore historical power alignments. Backlash actions span verbal and violent attacks to cultural erasure of marginalized group's history, language, literature, symbols/images, music, and representations through mainstream institutions. Counterstrategies must be waged to manage backlash and sustain flourishing potential at personal, family, community, and cultural levels.

The above conditions increase addiction prevalence and intensify the need for recovery while inhibiting recovery initiation and growth in recovery, but they also set the stage for the rise of recovery-focused cultural revitalization movements. It is in this context that recovery, recovery flourishing, recovery advocacy, and broader social activism become radical acts of personal and cultural survival and acts of self-creation and community reclamation. When you are a member of an oppressed group, liberation of self and achieving personal fulfillment are not enough and, when achieved in isolation, can leave one haunted by those left behind. One's people must be pulled up as one rises. To recover as an act of rebellion in this context is in the words of Albert Camus a "refusal to be the only one saved."[202] Complex trauma is a shared collective experience for historically oppressed minorities that exacts a physical, mental and emotional toll[203], engenders internalized stigma with broad effects on perception of self and others, but which can be ameliorated by collective membership esteem via decolonization of the history, identity, and aspirations of one's people.[204]

The breakthrough of consciousness spurred by the above understandings also can serve to stem the destructive behavior (e.g., drug use as a form of self-harm) that unfolds when rage and rebellion are turned inward on oneself. Cultural activism becomes a positive redirection of suicidal thoughts—from anomie and hopelessness to action.[205] There are multiple pathways of recovery initiation and recovery flourishing

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[200] Nutton, J., & Fast, E. (2015). Historical trauma, substance use, and indigenous peoples: Seven generations of harm from a "big event." *Substance Use & Misuse*, 50(7), 839–847. https://doi.org/10.3109/10826084.2015.1018755; Zhu, C., Keum, B. T. (2025). Flourishing through heritage: Instilling heritage culture as a pathway to Asian American men's positive mental health. *J Couns Psychol*., Dec 15. doi: 10.1037/cou0000855. PMID: 41396503.

[201] Maruna, S. (2025). Redeeming desistance: From individual journeys to a social movement. *Criminology*, 63, 5-25.

[202] Camus, A. (1957). *The rebel: An essay on man in revolt* (A. Bower, Trans.). Knopf, p. 56.

[203] Cénat, J. M. (2023). Complex racial trauma: Evidence, theory, assessment, and treatment. Perspect *Psychol Sci*., May;18(3):675-687. doi: 10.1177/17456916221120428. PMID: 36288462; PMCID: PMC10186562;

[204] Sanders, S. M., Williams, T. R., Berry, A. T., Garcia-Aguilera, C., Robinson, K., Martin, R., Jones, P. (2024). Internalized racism and mental health: The moderating role of collective racial self-esteem. *Behav Sci* (Basel). 2024 Oct 29;14(11):1003. doi: 10.3390/bs14111003. PMID: 39594303; PMCID: PMC11591433.

[205] Bowser, B. P., Bilal, R. (2001). Drug treatment effectiveness: African-American culture in recovery. *J Psychoactive Drugs*, Oct-Dec;33(4):391-402. doi: 10.1080/02791072.2001.10399924. PMID: 11824698.

within historically oppressed community[206], with rebellion constituting one such pathway. It remains unclear whether, or the degree to which, embracing a “freedom fighter” identity opens new avenues of long-term flourishing within the recovery experience.

To recover as an act of protest rests on the ideas/strategies of strike, boycott, confrontation, and cultural revolution—withdrawing of self from the addiction industrial complex, confronting the larger systems of oppression, and contributing to cultural revitalization. It is a refusal to have one’s mind, rage, voice, and actions anesthetized into submission and to have one’s body feed the insatiable greed of oppressive institutions. It is a declaration to the hustlers/grifters (individuals and organizations who view addicted people as a crop to be harvested for financial profit): “I refuse to offer my body and soul as fuel for your machine of exploitation.” It is in this context that the refusal to use drugs, commit criminal acts, neglect one’s children, or be dependent upon ‘helping institutions’ becomes a political as well as a personal act. Recovery as resistance by the individual feeds the growing resistance of the oppressed community.

A revolutionary movement of cultural revitalization can begin with a revolution within oneself. Matamonasa-Bennet, for example, found this style represented within men in a Great Lakes reservation community who transitioned from a pattern of self-destructive “Indian drinking” to an identity of sober “traditional men,” “human beings,” and “warriors” of their culture.[207] This metamorphosis involved both a rejection of Euro-American values and a process of “retraditionalization”—a deep embrace of Native cultural and spiritual values and practices or as they described "living life as it was meant to be lived”.[208] As one respondent in the Matamonasa-Bennet study noted, “How can you justify taking one drink if you know that this is the poison that has ruined the Nation?”[209]

Such rebellion does not have to be noisy or publicly performative. It can involve clarity of observation and understanding and a quiet refusal to participate in the destruction of oneself and one’s people. Such styles of recovery resistance, grounded in intracultural values and rituals, can be found within abstinence-based Native American

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[206] Venner, K. L., Hagler, K., Cloud, V., Greenfield, B. (2019). Native Americans resolve alcohol use disorder: "Whatever it takes or all that it takes". *Cultur Divers Ethnic Minor Psychol*., Jul;25(3):350-358. doi: 10.1037/cdp0000241. PMID: 30570290; Vose-O'Neal, A., Christmas, S., Alfaro, K. A., Dunigan, R., Leon, A. P., Hickman, D., Johnson, A., Kim, M. L., Reif, S. (2025). Understanding pathways to recovery from alcohol use disorder in a Black community. *Front Public Health*, May 1;13:1537059. doi: 10.3389/fpubh.2025.1537059. PMID: 40376060; PMCID: PMC12078236.

[207] Matamonasa-Bennet, A. (2017). “The poison that ruined the nation”: Native American men—Alcohol, identity, and traditional healing. *American Journal of Men’s Health*, 11(4), 1142-1154.

[208] Mohatt, G. V., Rasmus, S. M., Thomas, L., Allen, J., Hazel, K., Marlatt, G. A. (2008). Risk, resilience, and natural recovery: a model of recovery from alcohol abuse for Alaska Natives. *Addiction*, Feb;103(2):205-15. doi: 10.1111/j.1360-0443.2007.02057.x. PMID: 18042193

[209] Matamonasa-Bennet, A. (2017). “The poison that ruined the nation”: Native American men—Alcohol, identity, and traditional healing. American Journal of Men’s Health, 11(4), p. 1148; See also: Skewes, M.C. & Lewis, J. P. (2016). Sobriety and alcohol use among rural Alaska Native elders. *International Journal of Circumpolar Health*, 75, 30476; Spicer P. (2001). Culture and the restoration of self among former American Indian drinkers. *Soc Sci Med*., 53, 22740.

cultural revitalization movements[210], in the pronouncements of prominent Black leaders (from Frederick Douglass to Malcolm X)[211], and in efforts to create feminist frameworks of recovery that work for women.[212] Struggle and agitation against oppression and community-wide addiction can exist within a state of flourishing. One could even argue that in the presence of great injustice they must. And within this community of resistance is a vanguard of individuals who refuse to let others speak for them and who will express the collective voice of lived experience regarding the needs and aspirations of people seeking and in recovery. The honored civil rights activist John Lewis notably distinguished between bad and good trouble. Within the context of a growing international recovery advocacy movement, recovery flourishing as an act of rebellion could be framed as a journey from bad trouble to good trouble (agitation for positive personal and social change). One can flourish and still be a recovery troublemaker.

For some, indignation over injustice within the context of recovery flourishing extends to the recovery arena itself and to advocacy of pro-recovery drug policies and expansion of local and national recovery support resources. Such advocacy can flow from a shift in consciousness in which individuals experiencing addiction are seen as "a people" with a shared history and destiny, the former including a history of oppression that spans genocidal campaigns, mass incarceration, prolonged hospitalization, and iatrogenic medical interventions (e.g., toxic withdrawal schemes, innumerable electroconvulsive treatment, psychosurgery, harmful medications, confrontational 'therapies', sexual exploitation, and being medically discharged for drug use).[213] It is within this rising consciousness that one's own journey to recovery flourishing can become an overt act of social and political resistance. There is a tranquility within the experience of recovery flourishing; what the spirit of rebellion adds is a passion for social justice, militancy, and a sense of urgency.

This rebellious style of recovery brings unique rewards but also its own risks.[214] The recovery activist's passion for justice can tax one's capacity to sustain self-care;

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[210] 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.

[211] White, W., Sanders, M., & Sanders, T. (2006). Addiction in the African American community: The recovery legacies of Frederick Douglass and Malcolm X. *Counselor*, 7(5), 53-58; Sanders, W. (2025). Lessons from the recovery legacies of Frederick Douglass and Malcolm X. Accessed February 9, 2026 at https://www.museumofafricanamericanaddictionsrecovery.org/blog/2021/2/17/lessons-from-the-recovery-legacies-of-frederick-douglass-and-malcolm-x

[212] Kirkpatrik, J. (2025). *Women for Sobriety New Life Program. Women for Sobriety*, Quakertown, PA.

[213] Moos, R. H. (2012). Iatrogenic effects of psychosocial interventions: treatment, life context, and personal risk factors. *Subst Use Misuse*, Nov-Dec;47(13-14):1592-8. doi: 10.3109/10826084.2012.705710. PMID: 23186483.White, W. L. (1998, 2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Chestnut Health Systems; 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., Scott, C., Dennis, M. & Boyle, M. (2005). It's time to stop kicking people out of addiction treatment. *Counselor*, 6(2), 12-25.

[214] Burns, V. F., Wright, I., MacInnis, N., & Coombes, K. (2025). Disclosing recovery in academia: the role of stigma and recovery capital. *Addiction Research & Theory*, 1–14. https://doi.org/10.1080/16066359.2025.2549302; White, W., Stauffer, B., & Tarino, D. (2021). Personal

and activism. Recovery advocacy activism is not a program of personal recovery. For example, in spite of the Black Panther Party's vehement anti-hard-drug policy,[215] its conceptualization of drugs as a weapon of Black genocide, and its operation of a drug detoxification program, the social justice advocacy activities of several prominent Black Panthers (e.g., Eldridge Cleaver, Dr. Huey P. Newton, David Hillard, Afeni Shakur, Michael "Cetewayo" Tabor) were undermined by personal addiction.[216]

Recovery and recovery flourishing as acts of rebellion elevate these experiences to something greater than oneself, elevating the journey into and beyond recovery into something more epic, more heroic. It heightens awareness that we occupy critical links in the chain of history and that the choices we make and the lives we lead have the power to influence a future that we will not see but will be acted upon, for good or bad, by those we influence. Flourishing becomes more that nourishment of self; it becomes a way to honor the sacrifices, survival and aspirations of generations of people who have successfully or unsuccessfully sought escape from addiction.

Recovery initiation and recovery flourishing can be fueled by catalytic metaphors (epiphanies that provoke radical reinterpretations of self and the self-world relationship)) that differ widely across recovery-seeking populations. Rebellion as a journey to recovery flourishing among historically oppressed people can involve distinct themes and metaphors. For example in comparing mainstream recovery metaphors of those within recovery support groups rising out of the experience of historically oppressed people (e.g., women, people of color, LGBTQ+), one finds such differences in emphasis as *assertion of power (empowerment)* versus acceptance of *powerlessness*, a focus on *power within the self* versus *power greater than self*, *seeing the top* (hope) versus *hitting bottom* (pain), *discovery* versus *recovery*, *thriving* versus *surviving*, *self-affirmation* versus *humility*, *breaking silence* versus *achieving silence*, *acts of self-care* versus *service to others*, use of slave/master analogies to depict addiction and the experience of liberation, and an emphasis on family/community recovery in tandem with personal recovery.[217]

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privacy and public recovery advocacy. Posted at https://deriu82xba14l.cloudfront.net/file/386/Privacy-Paper-Final-1.pdf (from a blog series posted November-December 2020).

[215] Tabor, M. C. (1970). Capitalism plus dope equals genocide. Accessed February 13, 2026 at https://freedomarchives.org/Documents/Finder/DOC513_scans/Michael_Cetewayo_Tabor/513.Michael.Tabor.Capitalism.Dope.Genocide.pdf

[216] Hilliard, D. & Cole. L. (1993). *This side of glory: The autobiography of David Hilliard and the story of the Black Panther Party*. Little Brown & Company; Santos-Powell, S, (2021). Drugs and the Black Panther Party: A study in contradiction. An ideological and intimate history, 1966-1972. Stanford University, Department of History, https://purl.stanford.edu/qk190kc4704; Street, J. (2015). The shadow of the soul breaker: Solitary confinement, cocaine, and the decline of Huey P. Newton. *Pacific Historical Review*, 84(3), 333-363.

[217] Bowser, B. P., Bilal, R. (2001). Drug treatment effectiveness: African-American culture in recovery. *J Psychoactive Drugs*, Oct-Dec;33(4):391-402. doi: 10.1080/02791072.2001.10399924. PMID: 11824698; White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO; Rush, M. M. (2000). Power, spirituality, and time from a feminist perspective: correlates of sobriety in a study of sober female participants in Alcoholics Anonymous. *Journal of the American Psychiatric Nurses Association*, 6, 196–

Recovery rebellion involves clear recognition of the limitations imposed by one's environment, creative responses to those limitations, and assertive efforts to change self AND the environment—shifting from passive victim to actor/activist in addressing structural inequalities that inhibit recovery initiation and recovery flourishing. Recovery and recovery flourishing as acts of rebellion can be initiated as an impulse or be a calculated and sustained strategy (shaping and sustaining a recovery rebel consciousness). The former is likely to weaken and fade in the face of resistance, but the development of a sustained rebel consciousness can anchor long-term recovery and forge a platform for recovery flourishing. It can also involve not just the act of recovery initiation and recovery flourishing but challenging prevailing ideas about how such processes are best achieved.

A variation of recovery flourishing as rebellion is flourishing as an act of artistic expression. There are innumerable artists in addiction recovery, some of whom express their addiction and recovery experiences through widely varying artistic media. Among these are artists who use art as a mechanism of recovery advocacy and whose works are evident in the growing presence of recovery artist collectives, recovery art exhibitions, recovery art cafes, recovery mural projects, and recovery theatre productions, as well as artistic expression through music, film, dance, and literature—a recovery arts movement within the larger recovery advocacy movement.[218] But within the rubric of recovery flourishing, there is another publicly engaged artistic process and that is individuals who frame and orchestrate their own recovery growth as an artistic endeavor. In this context, the artist becomes both the creator and the creation—self as artistic product, self-creation as a conscious alternative to self-destruction, and self-creation as a healing force and offering to the suffering of others. This style, marked by a heightened sense of awareness (consciousness, mindfulness), reflects both the potential joy of self-creation and personal change as a gift to one's community and culture. Within this context, one's own evolving character/action/lifestyle becomes performative art designed to be observed and experienced—something that elicits thought, emotion (e.g., empathy, compassion), and action in the manner of other forms

202; She Recovers (2025). My Recovery Patchwork. Accessed December 31, 2025 at https://sherecovers.org/product/my-recovery-patchwork/; also see Redefining Recovery https://sherecovers.org/srf-redefining-recovery/; Smith, D. E., Buxton, M. E., Bilal, R., & Seymour, R. B. (1993). Cultural points of resistance to the 12-Step recovery process. *Journal of Psychoactive Drugs*, 25(1), 97–108. https://doi.org/10.1080/02791072.1993.10472596; Williams, C. with Laird, R. (1992). No hiding place: Empowerment and recovery for troubled communities. New York, NY: Harper San Francisco: For detailed discussion see White, W. & Chaney, R. (1992). Metaphors of transformation: Feminine and masculine. Chestnut Health Systems. Posted at https://deriu82xba14l.cloudfront.net/file/79/1992-Metaphors-of-Transformation.pdf.

[218] Sloan, C. (2021). The 'pop-up' recovery arts café: growing resilience through the staging of recovery community. *Research in Drama Education: The Journal of Applied Theatre and Performance*, 26(1), 9–23. https://doi.org/10.1080/13569783.2020.1844562

of artistic production. In this way, one's own healing and flourishing are offered as catalysts of community healing and revitalization.[219]

**Temporal Dimensions of Recovery Flourishing**

Temporal aspects of recovery and recovery flourishing include the timing of the onset of change, the duration of changes efforts, and the rate of change over time (i.e. the potential for exponential growth or decay).

The onset of recovery is immediately disruptive due to the radical changes it demands in one's daily life. It is quickly corrective, meaning that many dimensions of suffering subside with the reduction or cessation of drug use. It is slowly constructive, meaning that time is required to move beyond repair (problem subtraction) to create a new life (asset development, identity and lifestyle reconstruction). And it is potentially transformative, meaning that flourishing in recovery is attainable as an outcome of change efforts across multiple life domains.

Incremental enhancements in cognitive functioning and diminishment of depression and anxiety are common in early recovery[220], but post traumatic growth is not an inevitable outcome on the heels of drug deceleration/cessation. In fact, enhanced quality of life following remission is not a universal outcome across the spectrum of psychiatric disorders, including substance use disorders.[221] The peak period of emotional distress (e.g., anxiety, depression) within one's addiction career can sometimes occur some period of time after recovery initiation.[222] This is evident in looking at suicide risks in the transition from addiction to recovery. The high rate and degree of lethality of suicide attempts among addicted individuals declines with treatment and recovery initiation but remains higher during remission than in the general population.[223] The author has also observed something of a "midlife crisis in recovery"

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[219] Franklin, M. (2010). Global recovery and the culturally/socially engaged artist. In Peoples, D. (Ed.). *Buddhism and ethics*, 309-320. Ayuthaya, Thailand.

[220] Bates, M. E., Voelbel, G. T., Buckman, J. F., Labouvie, E. W., Barry, D. (2005). Short-term neuropsychological recovery in clients with substance use disorders. *Alcohol Clin Exp Res*., Mar;29(3):367-77. doi: 10.1097/01.alc.0000156131.88125.2a. PMID: 15770112; PMCID: PMC3059764; Verheul, R., Kranzler, H. R., Poling, J., Tennen, H., Ball, S., Rounsaville, B. J. (2000). Axis I and Axis II disorders in alcoholics and drug addicts: fact or artifact? *J Stud Alcohol*., Jan;61(1):101-10. doi: 10.15288/jsa.2000.61.101. PMID: 10627103.

[221] Rubio, J. M., Olfson, M., Villegas, L., Pérez-Fuentes, G., Wang, S., Blanco, C. (2013) Quality of life following remission of mental disorders: findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry*, May;74(5):e445-50. doi: 10.4088/JCP.12m08269. PMID: 23759465.

[222] 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; Fontesse, S., Chevallereau, T., Stinglhamber, F., Demoulin, S., Fiorito, A., Chatard, A., Jaafari, N., Maurage, P. (2024). Suicidal ideations and self-dehumanization in recently detoxified patients with severe alcohol use disorder: an experimental exploration through joint explicit-implicit measures. *J Addict Dis*., Oct-Dec;42(4):500-507. doi: 10.1080/10550887.2023.2292303. PMID: 38112194.

[223] Agosti, V., Levin, F. R. (2006). One-year follow-up study of suicide attempters treated for drug dependence. *Am J Addict*., Jul-Aug;15(4):293-6. doi: 10.1080/10550490600754333. PMID: 16867924;

("I'm sober, now what do I do?") occurring four to five years into the recovery process in which growth plateaus and feelings of stagnation deepen.[224] Such a crisis can be followed by clinical deterioration or trigger a stage of accelerating growth and flourishing.

As a professional field of inquiry and practice, we know very little about the transition from incremental growth in recovery to a state of flourishing. There is evidence that recovery capital increases incrementally with time in recovery.[225] This could indicate the potential for a tipping point of recovery capital growth that triggers entry into a sustained state of flourishing. The hypothesis proposed is that the greater the problem severity/complexity/duration and the lower the recovery capital, the longer the average time from recovery initiation and onset of flourishing. That lag is due to the amount of time required to clean up addiction's legacies and to rebuild personal assets. Such experiences need to be normatively mapped to guide expectations for those in recovery, their family members, and caregivers.

Key time-related questions include the following. What is the tipping point between growth within domains of recovery-supported growth and the onset of a state of flourishing across these domains? What period (temporal stability) is required to define a state of flourishing? Flow or peak experiences are moment-in-time events, whereas experiences of growth, wellbeing, and flourishing, while not necessarily permanent, are more time-expansive. Rather than define recovery flourishing as a state of terminal achievement, is it best to see such a state as a more fluid process that requires continual adjustments based on internal and external conditions? It is theorized that such continual adjustments are needed to maintain the balance and harmony that characterize recovery flourishing.[226]

There are also questions related to when a state of flourishing is most likely to occur within one's stage of life or stage of recovery. Rubio and colleagues in a prospective study of 348 individuals in recovery from alcohol use disorder found

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Fraser, R., Yeung, A., Glancy, M., Hickman, M., Jones, H. E., Priyadarshi, S., Horsburgh, K., Hutchinson, S. J., McAuley, A. (2025). Suicide in people prescribed opioid-agonist therapy in Scotland, United Kingdom, 2011-2020: A national retrospective cohort study. *Addiction*, Feb;120(2):276-284. doi: 10.1111/add.16680. PMID: 39438020; PMCID: PMC11707309; Rizk, M. M., Galfalvy, H., Miller, J. M., Milak, M., Parsey, R., Grunebaum, M., Burke, A., Sublette, M. E., Oquendo, M. A., Stanley, B., Mann, J. J. (2021) Characteristics of depressed suicide attempters with remitted substance use disorders. *J Psychiatr Res*. May;137:572-578. doi: 10.1016/j.jpsychires.2020.10.041. PMID: 33158553; PMCID: PMC8084874.

[224] "Eventually all of us come to an emotional crisis in recovery." Narcotics Anonymous World Services (NAWS, 2012) Living Clean. Vany Nuys, CA, p. 8.

[225] Heinrich, K. M., Collinson, B., Hillios, J. (2025). Flourishing during stages of substance use recovery among members of The Phoenix: a United States sober-active community. *Front Public Health*. 2025 Dec 9;13:1683975. doi: 10.3389/fpubh.2025.1683975. PMID: 41446527; PMCID: PMC12722921; Irish, A. J., Bowen, E. A., Richards, M. C. (2025). Preliminary estimates of recovery capital growth in early and middle stages: Social work practice implications. *J Soc Work Pract Addict*. 25(3):348-360. doi: 10.1080/1533256X.2025.2508789. PMID: 40958802; PMCID: PMC12435521.

[226] Unterrainer, H. F. (2025). On the wings of Icarus - the need for transcendence in addictive diseases. *Front Psychiatry*, Mar 21;16:1563871. doi: 10.3389/fpsyt.2025.1563871. PMID: 40191112; PMCID: PMC11968730.

progressive improvements in wellbeing and quality of life with time in recovery[227], but such improvements varied by recovery domain with improvements in physical health occurring within one year, psychological health improvements within one to four years, social relationships within four to ten years, and autonomy and self-acceptance achieved after more than ten years. Rates of abstinence decline over time following treatment cessation, but for those achieving abstinence, quality of life improves with time in recovery[228] as does self-reported meaning and purpose in life.[229] Such studies suggest that opportunities to achieve flourishing in recovery increase with duration of recovery. This aligns with research suggesting that lifetime SUD remission stability is achieved after four to five years of continuous remission[230], with SUD recurrence occurring after this period primarily as a function of changing life circumstances and decreased recovery vigilance.[231]

A recent review by Majdandzic and du Plooy suggests stable patterns of PTG over time among some individuals while others experience considerable variability (increases and decreases) in growth over time.[232] A study by Craft and colleagues suggests that one's status in early recovery is not a predictor of long-term recovery outcomes.[233] Many developmental models of recovery portray recovery stages in time

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[227] Rubio, G., Esteban Rodríguez, L., Sion, A., Ramis Vidal, L., Blanco, M. J., Zamora-Bayon, A., Caba-Moreno, M., Macias-Molina, A. I., Pérez-Sánchez, D., Rubio-Escobar, E., Ruiz-Diez, J., Marin, M., Arias, F., Lora, D., Jurado-Barba, R. (2023). How, when, and to what degree do people with alcohol dependence recover their psychological wellbeing and quality of life? The Madrid Recovery Project. *Front Psychiatry*, Jun 15;14:1130078. doi: 10.3389/fpsyt.2023.1130078. PMID: 37398602; PMCID: PMC10313403.

[228] Corner, T., Arden-Close, E., McAlaney, J. (2023). Wellbeing in addiction recovery: Does it differ across addictions? *Int J Environ Res Public Health*, Jul 16;20(14):6375. doi: 10.3390/ijerph20146375. PMID: 37510607; PMCID: PMC10379731; Rubio, G., Esteban Rodríguez, L., Sion, A., Ramis Vidal, L., Blanco, M. J., Zamora-Bayon, A., Caba-Moreno, M., Macias-Molina, A. I., Pérez-Sánchez, D., Rubio-Escobar, E., Ruiz-Diez, J., Marin, M., Arias, F., Lora, D., Jurado-Barba, R. (2023). How, when, and to what degree do people with alcohol dependence recover their psychological wellbeing and quality of life? The Madrid Recovery Project. *Front Psychiatry*, Jun 15;14:1130078. doi: 10.3389/fpsyt.2023.1130078. PMID: 37398602; PMCID: PMC10313403.

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(early, middle and late stages of recovery by years of continuous recovery), but the relationship between time and recovery flourishing has yet to be fully explored. Csikszentmihalyi suggests that excessively self-centered individuals have a diminished capacity for experiencing flow.[234] If true, it could mean that flourishing in recovery is not possible until addiction-induced narcissism is reversed through time in recovery and recovery-related alterations in personal character. Krentzman et al. found increased levels of purpose in life linked to probability of subsequent substance use disorder remission.[235] McInerney and colleagues similarly found that older adults with longer durations of recovery experienced greater meaning and purpose than those younger and with less years in recovery.[236]

The end of each stage of recovery stirs growing discontent signaling an imbalance requiring new adjustments that facilitate entry into the next chapter of one's life. The difference between being frozen in recovery and flourishing in recovery may is a willingness and capacity to listen and assertively respond to such signals. As *The Red Road to Wellbriety* suggests, *conflict precedes clarity*[237]; struggle (challenge rather than comfort) is an essential step in reaching a state of flourishing. The transition from addiction into recovery is one of experiencing repeated mini-deaths (of the old self) and rebirths (of a new self). To flourish in recovery is to understand and welcome such continued transformations. As suggested by Arthur Frank, "The Phoenix does not mourn what lies in its ashes; the serpent does not mourn its old skin."

Stable remission is likely foundational to flourishing for most individuals, but duration of remission may not be the best single predictor of recovery flourishing. Maturity (via older age and life experience) may be a more important predictor of flourishing than duration of remission[238], but this may diminish at the extreme of older adulthood based on physical challenges, loss of social support and meaningful

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activities, and increased isolation. The physical aging process in recovery can impose challenges that require new adaptations to achieve or maintain a state of flourishing.[239]

Post traumatic growth, increased psychological health and hardiness, and flourishing can occur through processes of transformative change (unplanned, climactic, positive, and permanent) or through incremental change (positive changes unfolding in stages over an extended time period).[240] The former are variably described as a rebirth, turning point, crossroad, wake-up call, epiphany, moment of clarity, profound realization, surrender, acceptance, breakthrough, or new outlook. The latter have been variably described as self-change, maturing out, and drift. Thes latter experiences may be sparked by such life transitions as geographical relocation, new relationships, parenthood, or engagement in new opportunities. It is suggested that while flourishing within particular life domains could occur through a sudden transformational change process, flourishing across life domains is far more likely to be an incremental process that reaches a tipping point of global flourishing. Both styles of change prompt intense processes of self-evaluation of past actions, beliefs, values, and relationships—from intrusive rumination (e.g., drug-related nostalgia, fear of addiction recurrence, self-sabotaging thoughts/emotions) to strategic rumination (assertive recovery focus and personal goal setting).[241]

Temporal aspects of recovery flourishing also involve the pace or rate of change. This involves the power of small changes whose effects are compounded over time, not unlike the power of compound interest in a savings account. This raises the potential for exponential recovery growth or decay. The implication here is not just the cumulative power of growth in long-term recovery but the potential benefits that could accrue from accelerating the rate of growth earlier within the recovery process via enhanced flourishing support services. If we want to increase recovery flourishing, we can do so by increasing the base level of assets, decreasing the age and stage of addiction at which recovery begins, and increasing the rate of change over time. Only long-term prospective studies will reveal what interventions may facilitate exponential growth in

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recovery and identify any well-intentioned interventions that may inadvertently impede such potential. Studies to date document potential for multiple recovery attempts prior to recovery durability,[242] with the pace of recovery and positive life satisfaction changes greatest during early months and years of recovery followed by incremental growth.[243]

The corollary to exponential growth in recovery is the concept of exponential recovery decay—deterioration within and across domains that, if not reversed, can accelerate at increasing speed over time. Declines in functioning within and across domains of recovery flourishing compound over time leading to decreased remission stability, erosion of global health and social functioning, weakening of person-community relationship, and increased risk of premature death. Each problem accompanying a return to excessive drug use does not exist in isolation. Problems in intimate and family relationships, physical and emotional health, work, employment, and so forth interact with each other, amplifying and accelerating each area and their collective effects. Timely Intervention in the decay within one domain of recovery flourishing via recovery checkups and assertive linkage to recovery support services could prevent the spread of decay to other domains and the larger risk of recovery destabilization.[244] Also needed is an exploration of the differences between interventions that promote recovery growth as long as the intervention continues (but whose effects erode as soon as intervention is discontinued) versus interventions that promote self-perpetuating growth not contingent on continued professionalized and commercialized services.

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**Family and Community Space/Landscapes: The Ecology of Recovery Flourishing**

Flourishing variables include addiction severity, complexity, and chronicity; levels of personal, family and community recovery capital; as well as such environmental influences as the density of local addiction / recovery spaces, social determinants of health, and larger culture influences on recovery initiation and maintenance.[245] Addiction, remission, recovery, and post-recovery flourishing are often portrayed as intrapersonal processes, but these experiences are nested within physical, psychological, social, and cultural spaces that can either inhibit or promote their achievement and maintenance.[246] Those spaces encompass family/home, neighborhood, neighborhood, school, work, leisure, faith, community, and culture.

Innumerable studies suggest that family and social support play a critical role in SUD recovery initiation and maintenance and quality of life in early recovery[247], but it remains unclear whether such support mediates recovery flourishing or if this

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experience is mediated by intrapersonal variables. White portrayed the resolution of severe drug problems as a journey between two worlds—from enmeshment in a culture of addiction to a parallel enmeshment in a culture of recovery, with addiction-supportive relationships replaced by recovery-supportive relationships.[248] Roxburgh and colleagues confirmed the value of the density of the latter relationships in early recovery but found the total number of close relationships a greater factor in later stages of recovery.[249] Such findings could inform future studies on styles of long-term recovery and recovery flourishing.

There is also the question of the potential for post traumatic growth and flourishing of the whole family as an outcome of SUD recovery of a family member. As to the potential for recovery-mediated family flourishing, there are numerous challenges that must be faced to achieve and maintain such a state. Recovery and recovery flourishing can require a radical readjustment of family life (developmental needs of each member), family relationships (adult intimacy needs, parent-child relationships, sibling relationships, extended family relationships, and family relationships with the community), and the structures of daily family life (e.g., roles, rules, and rituals). The effects of addiction on individual family members (e.g., compromised physical and emotional health) may require independent personal recovery processes.[250] Family flourishing is not an automatic outcome of personal SUD recovery; even after years of SUD recovery, families may not achieve satisfactory levels of functioning.[251] Flourishing requires more than overcoming the effects of addiction on family health and functioning and vacillating family responses—from assertive attempts at aid and control to emotional and relational detachment.[252] It also requires overcoming the strain of family restructuring following recovery initiation, the potential strain of discordant drug use, and the strain imposed by discordant growth.[253] Each of these areas of strain will be briefly highlighted.

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Brown and Lewis suggested three related propositions: 1) family survival of addiction involves prolonged adaptations in family roles, rules, rituals, and relationships that while keeping the family intact inflict harm on individual development and family health, 2) recovery initiation by an addicted family member can be traumatic for the family as a whole due to the radical changes recovery precipitates in these dimensions of family life, and 3) families that do not have scaffolding of social support to adapt to recovery-provoked changes may experience dissolution in spite of having survived the worst years of addiction.[254] The potential of a parallel process with recovery flourishing is highly likely.

The selection of intimate patterns (assortative mating) is a complex process influenced by a match between drug consumption patterns of the partners, meaning that drug use is important to each partner, mirrored and mutually influenced in their respective use patterns, or that heavy drug use by one partner meets various needs of the other partner in spite of the latter partner's abstinence or lower level of use.[255] This balance is critical to relationship satisfaction over time,[256] but is disrupted when one party initiates and sustains recovery without the other partner ceasing or decelerating their drug use[257]—an imbalance that can trigger increased SUD risk for the partner with lower drug use, recovery sabotage efforts by the partner of the person seeking recovery, or potential dissolution of the relationship.[258] (The author has observed innumerable

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cases in which a marriage, no matter how dysfunctional, endured all the harm addiction could inflict only to disintegrate some time into the recovery process.) The relationship readjustments necessitated by recovery initiation are a likely prerequisite to a state of family flourishing[259], but the nature of such adjustments may vary across different-sex and same-sex partner relationships.[260]

A similar process of readjustment is required in the face of asynchronous growth between the individual in recovery and their partner. This can be precipitated by the person in recovery using recovery as a fulcrum of personal growth without their partner experiencing a parallel process of growth—an asynchrony that inflicts increasing strain on the relationship. Recovery-induced changes in relationship dynamics (power dynamics / control and caretaking patterns[261]) can lead to acts of recovery sabotage by parents, partner, siblings, extended family and social network members.[262] For example, unresolved anger, power realignment (e.g., disciplining of children, control of family finances, sexual expectations), loss of emotional rewards and needs met in the victim/caretaker role (the need to be needed), and transfer of attention and praise to the addicted, now recovering, partner, can trigger efforts to sabotage (destabilize) a partner's recovery.[263] Such acts of sabotage may include invited or coerced substance use, purchasing drugs for partner, using drugs with partner, taking over partner responsibilities, and triggering emotional outbursts.[264] These behaviors are best viewed

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discrepant drinking. *J Consult Clin Psychol*., Feb;75(1):43-51. doi: 10.1037/0022-006X.75.1.43. PMID: 17295562; PMCID: PMC2289776; Leonard, K. E., Smith, P. H., Homish, G. G. (2014) Concordant and discordant alcohol, tobacco, and marijuana use as predictors of marital dissolution. *Psychol Addict Behav*. Sep;28(3):780-9. doi: 10.1037/a0034053. PMID: 24128287; PMCID: PMC4076345; Torvik, F. A., Røysamb, E., Gustavson, K., Idstad, M., Tambs, K. (2013). Discordant and concordant alcohol use in spouses as predictors of marital dissolution in the general population: results from the Hunt study. Alcohol Clin Exp Res., May;37(5):877-84. doi: 10.1111/acer.12029. PMID: 23384147; Wiersma, J. D., Fischer, J. L. (2014). Young adult drinking partnerships: alcohol-related consequences and relationship problems six years later. *J Stud Alcohol Drugs*, Jul;75(4):704-12. doi: 10.15288/jsad.2014.75.704. PMID: 24988269; PMCID: PMC4108609.

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as normal reactions to the extreme adaptations thrust upon the family as a result of recovery initiation rather than viewed as partner psychopathology. There are interventions that have been shown to enhance resilience and posttraumatic growth among partners of persons in recovery.[265]

There may also be unmet recovery expectations of the non-addicted partner. This can occur when the partner expectations of increased time and attention are not fulfilled due to recovery support activities (e.g., “I saw more of him when he was drinking than I do now.”) A similar process of asynchronous growth can occur when the non-addicted partner seeks their own growth and progressively detaches from their addicted partner. If balanced attention and support are not available to such couples, future flourishing is unlikely in the face of continued marital dissatisfaction and risk of relationship dissolution. Where family or partnership strain is lacking in recovery support, it may be necessary to create one’s own “family of choice” (recovery circle) that takes over family support functions.[266]

Studies of family factors that enhance the potential for human flourishing in the general population include clarity of expectations, expressed interest in present activity and experience, availability of choices, commitment to new experiences, and challenging opportunities.[267] The degree to which these apply to the recovery experience is unknown. There remains a paucity of studies on the relationship between personal recovery and family recovery and the same could be said for the relationship between personal flourishing and family functioning and health. The concept of family flourishing has yet to be explicated. The family response to individual flourishing and the stages and alignment of personal and family recovery warrant rigorous investigation as does the role of the extended family in supporting recovery-enabled flourishing of family members and Intra/Inter-family relationships.[268]

Recovery and recovery flourishing involve both processes of disconnection (of recovery-interfering relationships) and connection (formation of new recovery-supportive

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behavior in a clinical sample of alcohol-dependent clients and their partners, *Journal of Substance Abuse Treatment*, 26(4), 269-276, ISSN 0740-5472, https://doi.org/10.1016/j.jsat.2004.01.007.

[265] Ahmadzadeh, A., Khanjani, M. S., Azkhosh, M., Younesi, S. J., Ghaedamini Harouni, G. (2025). The effectiveness of resilience-based intervention on post-traumatic growth, resilience, coping skills, and perceived stress in women with addicted spouses. *Addict Health*, Jan;17:1510. doi: 10.34172/ahj.1510. PMID: 40458275; PMCID: PMC12127983.

[266] Bahl, N. K. H., Nafstad, H. E., Blakar, R. M., Landheim, A. S., Brodahl, M.. (2019) Multiple senses of community and recovery processes. A pilot study for a national evaluation of the experiences of persons with substance use problems receiving help and services from Norwegian municipalities. *J Community Psycho*l. 2019 Jul;47(6):1399-1418. doi: 10.1002/jcop.22194. PMID: 31038224; PMCID: PMC6767461.

[267] Csikszentmihalyi, M. (2002) *Flow: The classic work on how to achieve happiness: The psychology of happiness*. PIMLICO. Random House; Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. Harper Perennial.

[268] Moriarty, H., Stubbe, M., Bradford, S., Tapper, S., Lim ,B. T. (2011). Exploring resilience in families living with addiction. *J Prim Health Care*, Sep 1;3(3), 210-7. PMID: 21892423; Ronel, N., Haimoff-Ayali, R. (2010). Risk and resilience: the family experience of adolescents with an addicted parent. *Int J Offender Ther Comp Criminol*. Jun;54(3):448-72. doi: 10.1177/0306624X09332314. PMID: 19270268.

relationships).[269] Increases in recovery capital, which have been associated with recovery stability and higher quality of life in recovery, are in turn linked to enhanced connections to recovery-supportive family and social relationships.[270]

Another dimension of family flourishing involves the capacity to break intergenerational cycles of addiction and related problems. It remains unclear the extent to which parental recovery or recovery flourishing of a parent reduces such risks in their offspring.[271]

Work by Bahl and colleagues and Goshorn and colleagues (2023) underscores the potential role of geographical and relational communities in motivating recovery initiation and supporting the processes of long-term recovery.[272] These ecological influences include disengagement/distance from addiction supportive spaces and engagement with recovery social spaces and meaningful mutual support activities with others in recovery. This can be conceptualized as a destabilization of addiction-supporting assemblages (people, places, and things) and construction of new recovery supporting assemblages).[273] Such studies raise the question of whether recovery flourishing is highly idiosyncratic or something like recovery stability that emerges in the

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[269] Francis, M. W., Taylor, L. H., Tracy, E. M. (2020). Choose who's in your circle: how women's relationship actions during and following residential treatment help create recovery-oriented networks. *J Soc Work Pract Addict.,* 20(2):122-135. doi: 10.1080/1533256X.2020.1748975. PMID: 33414688; PMCID: PMC7787262; White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Hazelden.

[270] Best, D. & Ivers, J-H. (2021). Inkspots and ice cream cones: A model of recovery contagion and growth. *Addiction Research & Theory*, https://doi.org/10.1080/16066359.2021.1986699.

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[272] Bahl, N. K. H., Nafstad, H. E., Blakar, R. M., Landheim, A. S., Brodahl, M. (2019) Multiple senses of community and recovery processes. A pilot study for a national evaluation of the experiences of persons with substance use problems receiving help and services from Norwegian municipalities. *J Community Psychol*. Jul;47(6):1399-1418. doi: 10.1002/jcop.22194. PMID: 31038224; PMCID: PMC6767461; Bahl, N. K. H., Øversveen, E., Brodahl, M., Nafstad, H. E., Blakar, R. M., Ness, O., Landheim, A. S, Tømmervik, K. (2022). In what ways do emerging adults with substance use problems experience their communities as influencing their personal recovery processes? *J Community Psychol*., Sep;50(7):3070-3100. doi: 10.1002/jcop.22816. PMID: 35187694; PMCID: PMC9545888; Goshorn, J. R., Gutierrez, D., Dorais, S. (2023). Sustaining recovery: What does it take to remain in long-term recovery? *Subst Use Misuse*, 58(7):900-909. doi: 10.1080/10826084.2023.2196557. PMID: 37026405.

[273] Beate Larsen, I., Georg Friesinger, J., Strømland, M., Topor, A. (2022). You realise you are better when you want to live, want to go out, want to see people: Recovery as assemblage. *Int J Soc Psychiatry*. Aug;68(5):1108-1115. doi: 10.1177/00207640211019452. PMID: 34015980; PMCID: PMC9310138; White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

context of powerful environmental influences. In short, can a state of flourishing in recovery be socially transmitted?

Sandra Bloom and Don Coyhis and Richard Simonelli have proposed ecological models of healing that could inform future work on recovery flourishing.[274] Also of potential import are models of intervention that seek to address drug-related problems by expanding the space/landscapes within local communities in which recovery and flourishing in recovery are supported.[275]

> *The Wellbriety of the community creates a healing sanctuary--a culture of recovery--for the wounded individual, just as the growing Wellbriety of the individual feeds the strength of the community. 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.* –The Red Road to Wellbriety[276]

Such spaces can be targeted for development within communities defined by physical space (neighborhood, census tract, community, region, state) or by space demarcated by personal/social/cultural identification, e.g., tribal community, Black community, Latino community, LGBTQ+ community. Expanding recovery support resources that enhance the experience of connection and community may have enhanced value based on the diminishment of such connections within traditional settings: family, extended family, neighborhoods, schools, workplaces, and places of faith.[277] Communities of recovery can thus be thought of as replacement institutions that support global health, social functioning, community inclusion, and human flourishing.

Included within these expanding recovery support spaces are new recovery support institutions spanning the contexts of home, school, work, leisure, and faith: recovery residences (and anexos in Latino immigrant and migrant communities), recovery high schools, collegiate recovery programs, workplace recovery support programs, recovery ministries, recovery community centers, recovery cafes, recovery talent shows, recovery art exhibits, recovery adventure/sport/vacation venues, and increased opportunities to participate in recovery supportive projects related to recovery

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[274] Bloom, S. L. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge; Coyhis, D., & Simonelli, R. (2005). Rebuilding Native American Communities. *Child Welfare*, 84(2), 323–336. http://www.jstor.org/stable/45398728

[275] Burns, V. F. (2025). Recovering in place: what the concept of place can offer the field of recovery science. *Addiction Research & Theory*, 1–14. https://doi.org/10.1080/16066359.2025.2579015; Mills, J. (2017). Geographies of alcoholic recovery: Space, place, networks and identities. University of Manchester) (unpublished PhD Thesis); Gryczynski, J., Johnson, J., & Coyhis, D. (2007). The “Healing Forest” metaphor revisited: The seen and “unseen world” of drug use. *Substance Use & Misuse*, 42 (2-30, 475-484; White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58; 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.

[276] White Bison, Inc. (2002). *The Red Road to Wellbriety*. Colorado Springs, CO.

[277] Bellah, R. N., Madsen, R., Sullivan, W. M., Swidler, A., Tipton, S. M. (1996).: *Habits of the heart: individualism and commitment in American life*. Berkeley, CA: University of California Press.

language, history, art, theatre, film, and music.[278] To date, these institutions have focused on providing services that support SUD recovery initiation and maintenance. There is future potential in expanding resources that support post traumatic growth and flourishing for recovering individuals and families.[279] Such potential for family growth and flourishing also extends to families who have lost a family member due to drug use[280] despite the grief and stigma such families experience.[281]

The role of environment in recovery flourishing remains a key element within the recovery research frontier. We need to know how social determinants of health influence the potential, timing, and duration of recovery flourishing. We need to know which ecosystem layers exert the greatest positive effect on flourishing onset and maintenance. We do know from existing studies that recovery increases community engagement and related civic contributions. Kurtz & Fisher, in a study of AA and NA members, concluded that participation in community life and non-fellowship community service increased with time in recovery, suggesting a move from isolation and an adversarial person-community relationship to one of connection and contribution.[282] The Kurtz and Fisher findings were later confirmed in a series of Life in Recovery Surveys.[283] The heightened commitment to responsible citizenship flows from increased

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[278] Kramer, M. M., Londgren, J. (2020). Recovery's got talent: A positive-psychology intervention for people living in recovery. *Health Promot Pract*., Nov;21(6):862-864. doi: 10.1177/1524839920903706. PMID: 32081057; Pagano, A., García, V., Recarte, C., Lee, J. P. (2016). Sociopolitical contexts for addiction recovery: Anexos in U.S. Latino communities. *Int J Drug Policy*, Nov;37:52-59. doi: 10.1016/j.drugpo.2016.08.002. PMID: 27588569; PMCID: PMC5102756; Vilsaint, C. L., Tansey, A. G., Hennessy, E. A., Eddie, D., Hoffman, L. A., Kelly, J. F. (2025). Recovery housing for substance use disorder: a systematic review. *Front Public Health*, Mar 6;13:1506412. doi: 10.3389/fpubh.2025.1506412. PMID: 40115346; PMCID: PMC11922849; 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.

[279] Ahmadzadeh, A., Khanjani, M. S., Azkhosh, M., Younesi, S. J., Ghaedamini Harouni, G. (2025). The effectiveness of resilience-based intervention on post-traumatic growth, resilience, coping skills, and perceived stress in women with addicted spouses. *Addict Health*, Jan;17:1510. doi: 10.34172/ahj.1510. PMID: 40458275; PMCID: PMC12127983; Captain, C. (1989). Family recovery from alcoholism: Mediating family factors, *Nursing Clinics of North America*, 24(1), 55-67, ISSN 0029-6465, https://doi.org/10.1016/S0029-6465(22)01461-X; Rushton, C. M., Kelly, P. J., Larance, B., Townsend, C. J., Thomas, T., Beck, A. K. (2025). A qualitative exploration of affected family members' responses to methamphetamine use using the family resilience framework. *J Subst Use Addict Treat*., Jul;174:209710. doi: 10.1016/j.josat.2025.209710. PMID: 40286858.

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[281] Dyregrov, K., & Selseng, L. B. (2022). “Nothing to mourn, He was just a drug addict” - stigma towards people bereaved by drug-related death. *Addiction Research & Theory*, 30(1), 5–15. https://doi.org/10.1080/16066359.2021.1912327

[282] Kurtz, L. F., & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems*, 30(4), 875-904.

[283] Best, D. (2015). *The Australian life in recovery survey*. Melbourne, Australia: Turning Point, Eastern Health; Laudet, A.B. (2013). *Life in Recovery: Report on the Survey Findings*. Faces and Voices of

awareness of and compassion for human vulnerability and an accompanying obligation of restitution—repair of past harms to others and uplift of community life. Other studies confirm such potential growth and community contribution.

In a 2007 study, Washton found that individuals in addiction recovery experienced PTG at rates similar to people experiencing other types of traumas.[284] Ratteman, in a study of students in a recovery high school, found that academic achievement increased in tandem with recovery initiation and maintenance.[285] Best & Aston linked recovery achievements to tandem reductions in criminality, criminal justice system disengagement, and positive community engagement.[286] McGaffin and colleagues found that while the majority of individuals in recovery experienced moderate mental health, those in recovery twelve plus months had a rate of flourishing higher than that of the general population (39.8% versus 18%) confirming the potential for PTG and flourishing within the addiction recovery experience.[287] McGovern et al., in a study of Twelve-Step sponsorship, found that such service activity strengthened recovery identity, enhanced self-awareness, expanded social skills, enhanced psychological wellbeing and instilled a sense of purpose.[288] MacNeil and colleagues, in a study of 460 individuals with a past history of illicit drug dependence, reported 37.9% achieving "complete mental health" at the time of the survey.[289] Eddie and colleagues, in a survey of 2,002 individuals who had overcome an alcohol or other drug problem, found significant improvement across four domains of growth: self-improvement; family engagement; civic participation, and economic participation.[290] This collective body of research notes positive recovery achievements but does not distinguish general growth from a state of flourishing within these multiple domains of health and functioning.

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Recovery; McQuaid, R.J., Malik, A., Morrisey, M., & Baydack, N. (2017). Life in recovery from addiction in Canada. Canadian Centre on Substance Abuse; Turning Point (2015). *The Australian Life in Recovery Survey*. Turning Point.

[284] Washton, L. J. (2007). The silver lining in the clouds: Factors influencing addiction-related growth. ProQuest Dissertations and Theses. Cited in Horoosh & Freedman, 2017.

[285] Rattermann, M. J. (2014). Measuring the impact of substance abuse on student academic achievement and academic growth. *Advances in School Mental Health Promotion*, 7(2), 123–135. https://doi.org/10.1080/1754730X.2014.888225

[286] Best, D., & Aston, E. (2015). Long-term recovery from addiction: Criminal justice involvement and positive criminology? In N. Ronel & D. Segev (Eds.), *Positive criminology* (pp. 177–193). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781315796536-13

[287] McGaffin, B. J., Deane, F. P., Kelly, P. J., & Ciarrochi, J. (2015). Flourishing, languishing and moderate mental health: Prevalence and change in mental health during recovery from drug and alcohol problems. *Addiction Research and Theory*, 23(5), 351–360. http://dx.doi.org/10.3109/16066359.2015.1019346; McGaffin, B. J., Deane, F. P., Kelly, P. & Blackman, R. J. (2017). Social support and mental health during recovery from drug and alcohol problems. *Addiction Research and Theory*, 26(5), 386-395.

[288] McGovern, W., Addison, M., McGovern, R. (2021). An exploration of the psycho-social benefits of providing sponsorship and supporting others in traditional 12 Step, self-help groups. *Int J Environ Res Public Health*, Feb 24;18(5):2208. doi: 10.3390/ijerph18052208. PMID: 33668094; PMCID: PMC7967695.

[289] MacNeil, A., Fuller-Thomson, E. (2023). Factors associated with recovery and flourishing mental health in a national sample of Canadians with a history of illicit drug dependence. *Int J Ment Health Addiction*, 21, 81–95. https://doi.org/10.1007/s11469-021-00579-y

[290] Eddie, D., White, W. L., Vilsaint, C. L., Bergman, B. G. & Kelly, J. F. (2021). Reasons to be cheerful: Personal, civic, and economic achievements after resolving an alcohol or drug problem in the United States population. *Psychology of Addictive Behaviors*, 35(4):402-414. doi: 10.1037/adb0000689.

Novak and colleagues suggest that future work on flourishing may encompass harmony with other people and the environment—a process of collective flourishing.[291] The import of such social reconstruction is underscored by Jason and colleagues' finding in a study of recovery residences that recovery maintenance was predicted not by personal recovery capital but by the total recovery capital of all members within one's residence—suggesting a social contagion effect of successful recovery.[292] They concluded that recovery could be considered a "team sport" in which personal achievement was shaped by team achievement. Similarly, Sanders et al. found that collective racial self-esteem (i.e. pride in the achievements of one's people) moderates the personal trauma and distress experienced from internalized racism and oppression.[293]

The potential for *communal healing* raises two interesting questions: 1) Does flourishing in recovery flow from the self (an intrapersonal process), from the community (an outcome of community enrichment), or from a synergy within the person-community relationship (an interpersonal process)? and 2) Is recovery flourishing contagious (can it be transmitted via social contact)? Confirming the latter proposition would open a whole new arena of service interventions aimed at increasing the quality of life and social contributions of recovering individuals and families. Indicating such potential is a study by Walt and colleagues who found positive effects of living in a recovery residence mediated by high quality, harmonious relationships with one's housemates.[294] This finding suggests that social environment as well as intrapersonal factors influence recovery outcomes.

Numerous recovery mutual aid groups were founded in the discovery that their members could achieve together what they had been unable to achieve alone.[295] Post traumatic growth and flourishing in addiction recovery are often experienced as a process of shared healing, replenishment, and growth rituals.[296] Such shared activities include 1) centering rituals (contemplative/stillness practices such as prayer, meditation, mindful self-reflection, meditation, breathwork, savoring, yoga, daily goal setting, end-of-

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[291] Novak, L. F., Fowers, B. J., Kiknadze, N. C., & Calder, A. J. (2024). A close analysis of eight flourishing measures. *The Journal of Positive Psychology*, 20(1), 72–82. https://doi.org/10.1080/17439760.2024.2322468

[292] Jason, L. A., Guerrero, M., Salomon-Amend, M., Stevens, E., Light, J. M., Stoolmiller, M. (2021). Context matters: Home-level but not individual-level recovery social capital predicts residents' relapse. *Am J Community Psychol*., Jun;67(3-4):392-404. doi: 10.1002/ajcp.12481. PMID: 33296504; PMCID: PMC9149681.

[293] Sanders, S. M., Williams, T. R., Berry, A. T., Garcia-Aguilera, C., Robinson, K., Martin, R., Jones, P. (2024). Internalized racism and mental health: The moderating role of collective racial self-esteem. *Behav Sci* (Basel), Oct 29;14(11):1003. doi: 10.3390/bs14111003. PMID: 39594303; PMCID: PMC11591433.

[294] Walt, L., Lupei. M., Jason, L. A. (2022). Former substance abusing women, interpersonal relationships and social cognition: Social comparison & sober housemate harmony predict women's abstinence-specific efficacy. *J Prev Interv Community*., Apr-Jun;50(2):137-150. doi: 10.1080/10852352.2021.1934942. PMID: 34132160.

[295] Alcoholics Anonymous World Services, Inc. (1981). *Twelve Steps and Twelve Traditions*. New York, p. 151.

[296] Haroosh, E., & Freedman, S. (2017, September). Posttraumatic growth and recovery from addiction. *European Journal of Psychotraumatology*, 8 (1.), 1–6. https://doi.org/10.1080/20008198.2017.1369832

day self-evaluation),[297] 2) mirroring rituals (face-to-face or online sharing of “experience, strength and hope” with kindred spirits and aspirational role models),[298] 3) acts of self-care and care of one’s inner-circle,[299] and 4) unpaid acts of service to others (expressions of gratitude and redemptive justice).[300] These rituals constitute regulatory mechanisms that balance activities and experiences across the domains of recovery.

The above four rituals may remain meaningful over time, but the activities within them often require refinement over the course of recovery. Such rituals must continually be adapted and refined based on changes in self and in one’s life circumstances. Any over-routinization of such rituals risks losing their replenishment and growth value. Included within these rituals are principles of mutuality and reciprocity through which one is nourished by helping others grow and flourish. In this way, flourishing of the individual is only sustained by flourishing of those with whom one is most deeply connected. Such collective healing and collective achievement can be viewed in certain multigenerational Twelve Step sponsorship families. Communal healing comes from a special connection and flow of feelings that rise within gatherings of people who know each other, see each other, and accept each other without a whiff or whisper of contempt or fear.[301] Flourishing in recovery within many pathways of recovery slips from a focus on individual experience/identity to a relational experience/identity similar to the African principle of Ubuntu—“I am because we are,” or by extension, “I flourish when we flourish.”[302]

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[297] Celebrate Recovery (2025). Celebrate Recovery 8 Principle. Accessed December 29, 2025 at https://celebraterecovery.com/wp-content/uploads/2025/10/CR-8-Principles.pdf; Fudale, R., Matri, M. (2025). Short prayer-based interventions for addiction recovery in underserved populations: A systematic review. *Cureus*, Sep 7;17(9):e91769. doi: 10.7759/cureus.91769. PMID: 41063899; PMCID: PMC12503004; Krishnan A. (2024). Integrative treatment for substance use disorders: Improving outcomes through evidence-based practice of yoga-derived breathwork and meditation. *J Addict Med*. 2024 Mar-Apr 01;18(2):103-109. doi: 10.1097/ADM.0000000000001263. PMID: 38258889; Parisi, A., Roberts, R. L., Hanley, A. W., Garland, E. L. (2022). Mindfulness-oriented recovery enhancement for addictive behavior, psychiatric distress, and chronic pain: A multilevel meta-analysis of randomized controlled trials. *Mindfulness* (N Y). 13(10):2396-2412. doi: 10.1007/s12671-022-01964-x. PMID: 36124231; PMCID: PMC9476401.

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[300] McGovern, W., Addison, M., McGovern, R. (2021). An exploration of the psycho-social benefits of providing sponsorship and supporting others in traditional 12 Step, self-help groups. *Int J Environ Res Public Health*, Feb 24;18(5):2208. doi: 10.3390/ijerph18052208. PMID: 33668094; PMCID: PMC7967695; Riessman, F. (1965). The "helper" therapy principle. Social Work, 10(2), 27–32; White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden; Zemore, S. E., Kaskutas, L. A., & Ammon, L. N. (2004). In 12-step groups, helping helps the helper. *Addiction*, 99(8), 1015-1023. doi: 10.1111/j.1360-0443.2004.00782.x

[301] Dekkers, A., Vos, S., & Vanderplasschen, W. (2020). “Personal recovery depends on NA unity.”: An exploratory study on recovery-supportive elements in Narcotics Anonymous Flanders. *Substance Abuse Treatment, Prevention, and Policy*, 15, 53.

[302] Ogude, J., Paulson, S. & Strainchamps, A. (‘I am because we are’: An interview with James Ogude.” Accessed February 10, 2026 at https://chcinetwork.org/ideas/i-am-because-you-are-an-interview-with-james-ogude

Recovery flourishing demands a new social contract between the individual and the community that involves key principles (restorative justice, forgiveness) and practices (amends, restitution, civic contribution). Individuals and families in recovery from addiction ("wounded healers") constitute valuable community assets—sources of support for other individuals and families seeking recovery from addiction and other traumatic experiences. Recovery from addiction offers the potential to far transcend SUD remission by achieving levels of personal meaning and social contribution far beyond what might have been possible without the recovery experience. For some people, recovery initiation is a catalyst for formal educational pursuits and a style of self-directed and lifelong learning[303] as well as a pursuit of meaning and service.[304] A study by Crutchfield & Güss of 195 individuals in recovery suggests a reciprocal influence in which recovery spurs education advancement and subsequent educational achievement bolsters recovery durability and quality of life.[305] For some, this style of learning is both liberating and transformative.[306] White & Best have suggested that recovery can be socially transmitted by recovery *carriers/champions*.[307] It is unclear whether such individuals constitute a thriving subgroup of individuals in recovery and the degree to which recovery flourishing is also a contagious phenomenon.

**Cautions Related to Flourishing Research**

This review has to this point portrayed recovery flourishing as a uniformly positive experience and suggested the potential benefits of further recovery flourishing studies. However, there are potential risks involved in such explorations. First, it cannot be assumed that all research findings on recovery flourishing will be positive. For example, while preliminary results on recovery achievements are positive[308], it could be demoralizing for people seeking and in recovery if future research revealed that such flourishing is a rare phenomenon, is less likely to occur as part of the addiction recovery experience compared to recovery from other sources of trauma, or that flourishing is only likely to occur years after recovery initiation. Excessive popularization of the

[303] Rowley, J. (2012). Addiction recovery and adult education. (Doctoral dissertation), Staffordshire University. Accessed November 15, 2025 at https://www.academia.edu/22745707/Addiction_Recovery_and_Adult_Education

[304] Park, C. (2013). The meaning making model: A framework for understanding meaning, spirituality, and stress-related growth in health psychology. *The European Health Psychologist*, 2(15), 40–47. https://doi.org/10.1037/a0013348; Triplett, K. N., Tedeschi, R. G., Cann, A., Calhoun, L. G., & Reeve, C. L. (2012). Posttraumatic growth, meaning in life, and life satisfaction in response to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, 400-410. doi: 10.1037/a0024204

[305] Crutchfield, D. A., & Güss, C. D. (2018). Achievement linked to recovery from addiction: Discussing education, vocation, and non-addict identity. *Alcoholism Treatment Quarterly*, 37(3), 359–376. https://doi.org/10.1080/07347324.2018.1544058.

[306] Doyle, P. (2017). Towards a quality framework for adult learners in recovery: Ensuring quality with equity. Adult Learner: *The Irish Journal of Adult and Community Education*, 33-42.

[307] White, W. & Best, D. (2026) Social contagion and addiction recovery. Unpublished paper.

[308] Eddie, D., White, W. L., Vilsaint, C. L., Bergman, B. G. & Kelly, J. F. (2021). Reasons to be cheerful: Personal, civic, and economic achievements after resolving an alcohol or drug problem in the United States population. *Psychology of Addictive Behaviors*, 35(4):402-414. doi: 10.1037/adb0000689.

concept of recovery flourishing could also set recovery expectations at unrealistic levels, particularly for individuals so severely damaged as to make reaching a state of flourishing unlikely if not impossible or at best a prolonged and daunting process. For such individuals, just some semblance of normality may be experienced as flourishing.[309] As suggested by Human-Friedrich Untertrainer:

> "It may be more beneficial for some individuals in recovery to remain in the penumbra—the softer, more manageable light—rather than striving for the full blinding sun. Recovery, like the myth of Icarus, requires balance, humility, and a respect for one's own limitations."[310]

Second, Caution must be taken in dichotomizing those who have and have not achieved a state of flourishing. One risks overgeneralization to the point of caricature in such comparisons. Flourishing and drug use can coexist, less so in addiction over time, and recovery is not a guaranteed state of universal bliss. People claiming recovery status may continue to suffer and commit acts of callous injury to self and others. But the author does find considerable consistency in the qualities observed in recovering people who appear to be flourishing. Determining whether these are objectively verified qualities or the author's own perceptual biases must await definitive studies. There is a risk that in detailing addiction-inflicted-damage that we deny the humanity of people who are addicted—a process of othering (objectification) that renders us accomplices in acts of aggression against them as individuals and as a people who share our vulnerabilities and aspirations.

Similarly, inadvertent casting of levels of recovery growth and flourishing into categories of superiority and inferiority could have adverse consequences given that many factors influencing recovery achievements are beyond an individual's control, e.g., shaming people for failure to flourish whose shortfalls may be more attributable to social determinants of health than inadequacy of personal effort. It may turn out that flourishing within the recovery experience is highly influenced not by character or level of effort but by privilege and its related access to resources. Such superiority/inferiority categorization could also risk creating intragroup stigma and a disruptive new class structure within communities of recovery.[311] The creation of such an elite class of high

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[309] Brookfield, S., Fitzgerald, L., Selvey, L., Maher, L. (2021). "We're supposed to be a family here": An ethnography of preserving, achieving, and performing normality within methamphetamine recovery. *SSM Popul Health*, Nov 19;16:100969. doi: 10.1016/j.ssmph.2021.100969. PMID: 34901376; PMCID: PMC8637633; Nettleton, S., Neale, J., Pickering, L. (2013). 'I just want to be normal': An analysis of discourses of normality among recovering heroin users. *Health* (London). 2013 Mar;17(2):174-90. doi: 10.1177/1363459312451182. PMID: 22763795.

[310] Unterrainer, H. F. (2025). On the wings of Icarus - the need for transcendence in addictive diseases. *Front Psychiatry*, Mar 21;16:1563871. doi: 10.3389/fpsyt.2025.1563871. PMID: 40191112; PMCID: PMC11968730, p. 4.

[311] Gunn, A. J., Sacks, T. K., Jemal, A. (2018). "That's not me anymore": Resistance strategies for managing intersectional stigmas for women with substance use and incarceration histories. *Qual Soc Work*., Jul;17(4), 490-508. doi: 10.1177/1473325016680282. PMID: 30116159; PMCID: PMC6091228; Sibley, A. L., Schalkoff, C. A., Richard, E. L., Piscalko, H. M., Brook, D. L., Lancaster, K. E., Miller, W. C., Go, V. F. (2020). "I was raised in addiction": Constructions of the self and the other in discourses of

functioning individuals within a local recovery community risks potential cult-like shunning, scapegoating, and extrusion of the lowest functioning individuals seeking recovery as well as splintering an egalitarian community into factions and cliques. It is in this way that people in recovery could become accomplices in the sickness and death of those in the greatest need of recovery support. Such dichotomization may also inadvertently create impossible standards/expectations of perfection that are a set-up for failure, frustration, and clinical regression.

There is value in exploring the phenomenon of recovery flourishing, but we must do so cautiously. Seeking or bringing attention to the state of flourishing could undermine flourishing values (e.g., humility), spur ego-inflation, weaken social connections within recovery communities, and, as a result, erode the flourishing experience. This raises the question of how to disseminate information about recovery flourishing without undermining the very condition we are trying to promote.

Third, a related risk of over-popularization of the recovery flourishing concept is that flourishing, like the contested concept of recovery, will be diluted to convey even the smallest increments of positive change. If flourishing, like recovery, becomes everything, then it becomes nothing—a conceptual death by dilution. The author anticipates a day when the concept of recovery flourishing will be culturally and professionally celebrated as a counterweight to the present obsession with trauma. My fear is that recovery flourishing will become a “flavor of the month” phenomenon within the addictions field and larger culture leading to brief superficial investigation and financial exploitation only to then be cast aside as the newest fad topic arises.

Fourth, there is the potential that what looks on the surface like flourishing is actually a substitution of one excessive/compulsive behavior for another— not freedom, but an exchange of prisons.[312] Substitution refers to failure in one area of self-control replaced by failed self-control in other areas of one’s life. Such substitution can take many forms: the common substitution of one drug for another[313] or obsession with work, money, possessions, power/control, social attention/approval/prestige, digital obsession, love, emotional drama, sex, food, exercise, beauty (mirror worship), body modification, performative dress, risk/thrill-seeking (gambling, extreme sport/adventure), or religious/political extremism. It is also not uncommon in early recovery for a toxic relationships to be “our latest drug of choice.”[314] Such substitutions can serve multiple functions over time: distraction, isolation, or medicating unpleasant emotions or

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addiction and recovery. *Qual Health Res*., Dec;30(14):2278-2290. doi: 10.1177/1049732320948829. PMID: 33148139; PMCID: PMC7649922.

[312] Sinclair, D. L., Sussman, S., Savahl, S., Florence, M., Adams, S., Vanderplasschen, W. (2021). Substitute addictions in persons with substance use disorders: A scoping review. *Subst Use Misuse*, 56(5):683-696. doi: 10.1080/10826084.2021.1892136. PMID: 33749518.

[313] Kim, H. S., Hodgins, D. C., Garcia, X., Ritchie, E. V., Musani, I., McGrath, D. S., von Ranson, K. M. (2021). A systematic review of addiction substitution in recovery: Clinical lore or empirically-based? *Clin Psychol Rev*. 2021 Nov;89:102083. doi: 10.1016/j.cpr.2021.102083. PMID: 34536796.

[314] Narcotics Anonymous World Services (NAWS, 2012) Living Clean. Vany Nuys, CA, pp. 159-160.

symptoms of physical/psychiatric illness.[315] Studies of recovery from these addiction varieties across drugs/behavioral choices note remarkable similarities, including progressive growth and quality of life over time in recovery.[316]

Such substitution can produce achievement in one area at the expense of a broadly balanced and fulfilling life. SUD remission and recovery free the time, energy, money, and devotion once tied compulsively to the drug experience. These dimensions of living can then be channeled, sometimes excessively, into other domains of experience. That channeling process, which can promote or further inhibit health and global functioning, can be categorized as *obsessive* (pathogenic) *passion* or *harmonious* (salutogenic) *passion*.[317] The same could be said for experiences of flow. One could, for example, envision a terrorist experiencing a state of flow as he or she meticulously constructs a bomb or stares through the scope of a rifle. Flourishing could be thought of as flow constrained by prosocial values. There is the potential of any flow activity to become addictive, thus the need for self-monitoring and efforts of rebalancing.

High levels of passion contribute to recovery stability but may not provide sustainable long-term benefits.[318] Excessive pursuits can for a time result in a high level of self- and other-perceived flourishing. I would suggest, however, that rather than a state of recovery flourishing, these behavioral patterns represent a common stage of substitution within the recovery process that precedes a balancing of attention and achievement across the domains of human flourishing. What distinguishes recovery flourishing from transitional substitution are the dimensions of balance and harmony that spans these areas of potential achievement as well as the depth of personal meaning and social contribution garnered by such balance and harmony.

Other unanticipated outcomes of recovery flourishing are possible, e.g., the earlier noted asynchronous growth of recovering individuals and their partners and family members could lead to conflict and relationship/family dissolution. Research documenting any such risks should be accompanied by suggested strategies for their clinical and personal management.

The speculations offered in this monograph include numerous limitations. Studies to date of PTG and flourishing among individuals in recovery from addiction are limited

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[315] Sinclair, D. L., Sussman, S., Savahl S, Florence, M., Vanderplasschen, W. (2023). Narcotics Anonymous attendees' perceptions and experiences of substitute behaviors in the Western Cape, South Africa. *Subst Abuse Treat Prev Policy*, Jul 5;18(1):40. doi: 10.1186/s13011-023-00552-z. PMID: 37408038; PMCID: PMC10324242.

[316] Corner, T., Arden-Close, E., McAlaney, J. (2023). Wellbeing in addiction recovery: Does it differ across addictions? *Int J Environ Res Public Health*, Jul 16;20(14):6375. doi: 10.3390/ijerph20146375. PMID: 37510607; PMCID: PMC10379731.

[317] Vallerand, R. J., Blanchard, C., Mageau, G. A., Koestner, R., Ratelle, C., Leonard, M., Gagne, M., Marsolais, J. (2003). Les passions de l'ame: on obsessive and harmonious passion. *J Pers Soc Psychol*., Oct;85(4):756-67. doi: 10.1037/0022-3514.85.4.756. PMID: 14561128.

[318] Lewis, L. E., Mills, D. J., Bergman, B. G., Kimball, T. G., Gerber, W.. (2025). Examining the dualistic model of passion in addiction recovery. *Front Public Health*, Feb 26;13:1519430. doi: 10.3389/fpubh.2025.1519430. PMID: 40078761; PMCID: PMC11897514.

by challenges of definition and measurement, selection bias rising from convenience samples, samples dominated by participants from the United States and other Western countries, the lack of control groups, self-report without independent verification of functional status, and data drawn from cross sectional (point in time) rather than prospective studies that measure changes in status over prolonged periods of time compared to matched control groups. Convenience sampling to study PTG and flourishing in addiction recovery is likely to attract those who embrace a recovery identity versus those with lower problem severity/complexity/chronicity who have resolved an alcohol or other drug problem without participating in addiction treatment or a recovery mutual aid group. Such studies are also more likely to attract those with the most positive experiences in recovery. Future studies will benefit from independent (biological/behavioral) measures of recovery flourishing rather than solely relying on self-report as well as inclusion of more diverse study samples. Finally, most of what we as a field know about flourishing in recovery is drawn from the experience of adults—findings that may need considerable refinement if not complete rethinking when applied to adolescents and transition-age youth.[319] In short, future research is needed to develop evidence-based principles and practices of recovery flourishing.

**Implications for Service Design, Delivery and Evaluation**

The potential service design and clinical implications of recovery flourishing could include the following indications:

1) Increasing representation of people with lived experience of recovery flourishing within the addiction treatment and recovery support services workforce—offering visible role models of recovery flourishing and integrating experiential, clinical, and scientific ways of knowing,
2) Integrating biological, psychological, social, spiritual, and cultural perspectives within the design of services focused on recovery initiation/maintenance and enhanced quality of life in recovery,[320]
3) Including pre and post flourishing measures within addiction treatment intake and follow-up data collection and in formal post-treatment outcomes studies,
4) Visibly acknowledging the potential for personal/family recovery flourishing along with the risks of asynchronous growth within all levels of clinical care in all recovery support service settings,

[319] Eekhoudt, C.R., Henry, K.J., Friesen, D. et al. (2026). Reimagining recovery: a commentary centering youth and caregiver voices on substance use recovery and healing from across British Columbia, Canada. *Subst Abuse Treat Prev Policy.* 21, 9 (2026). https://doi.org/10.1186/s13011-025-00688-0; Schoenberger, S.F., Park, T.W., dellaBitta, V. et al. (2022). "My life isn't defined by substance use": Recovery perspectives among young adults with substance use disorder. *J Gen Intern Med*, 37, 816–822 (2022). https://doi.org/10.1007/s11606-021-06934-y; Skogens, L. & von Greiff, N. (2020). Recovery processes among young adults treated for alcohol and other drug problems: A five-year follow-up. J. *Nordic Studies on Alcohol and Drugs*, 37, 338-351.

[320] Galanter, M., White, W. L., Khalsa, J., Hansen, H. (2024). A scoping review of spirituality in relation to substance use disorders: Psychological, biological, and cultural issues. *J Addict Dis*., Jul-Sep;42(3):210-218. doi: 10.1080/10550887.2023.2174785. PMID: 36772834.

5) Supporting realignment of family relationships, roles, rules and rituals across the stages of personal and family recovery,
6) Strategically sequencing/combining interventions of “getting into oneself” and “getting out of oneself” across the stages of personal and family recovery.
7) Integrating elements of lifestyle medicine (e.g., nutrition, exercise, sleep, mindfulness-based interventions, etc.) into addiction medicine and the mainstream menu of addiction treatment and post-treatment recovery support services,[321]
8) Expanding access to activities that open pathways to recovery flourishing within in-treatment and post-treatment recovery support services and within local communities, e.g., sport, adventure, music, art, theatre, etc.,[322]
9) Identifying those individuals least likely to experience recovery flourishing for enhanced levels of recovery support services,
10) Supporting development and health of addiction treatment organizations, grassroots recovery community organizations, and personal recovery growth resources in the larger community,
11) Increasing efforts to reconstitute a volunteer workforce within the addictions field via recruitment of individuals who are flourishing and whose volunteer services activities could deepen that experience,
12) Mobilizing of people flourishing in recovery into a Recovery Corps service organization whose mission is focused on volunteer community service,
13) Integrating research findings on recovery flourishing into national and local anti-stigma campaigns, and
14) Supporting recovery-supportive cultural revitalization movements and related flourishing opportunities within historically oppressed and currently marginalized communities.

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[321] Heinrich, K. M., Patterson, M. S., Collinson, B., Streetman, A. E. (2025). Exercise as medicine for addiction recovery. *Curr Sports Med Rep*. 2025 Aug 1;24(8):235-239. doi: 10.1249/JSR.0000000000001271. PMID: 40758788; LaBelle, O., Hastings, M., Vest, N., Meeks, M., Lucier, K. (2023). The role of mindfulness, meditation, and peer support in recovery capital among Recovery Dharma members. *J Subst Use Addict Treat*., Feb;145:208939; Parisi, A., Roberts, R. L., Hanley, A. W., Garland, E. L. (2022). Mindfulness-oriented recovery enhancement for addictive behavior, psychiatric distress, and chronic pain: A multilevel meta-analysis of randomized controlled trials. *Mindfulness* (N Y). 13(10):2396-2412. doi: 10.1007/s12671-022-01964-x. PMID: 36124231; PMCID: PMC9476401; Patterson, M. S., Spadine, M. N., Graves Boswell, T., Prochnow, T., Amo, C., Francis, A. N., Russell, A. M., Heinrich, K. M. (2022). Exercise in the treatment of addiction: A systematic literature review. *Health Educ Behav*. Apr 29:10901981221090155. doi: 10.1177/10901981221090155. PMID: 35484950; Sancho, M., De Gracia, M., Rodríguez, R. C., Mallorquí-Bagué, N., Sánchez-González, J., Trujols, J., Sánchez, I., Jiménez-Murcia, S., Menchón, J. M. (2018). Mindfulness-based interventions for the treatment of substance and behavioral addictions: A systematic review. *Front Psychiatry*, Mar 29;9:95. doi: 10.3389/fpsyt.2018.00095. PMID: 29651257; PMCID: PMC5884944.

[322] Bickel, W. K., Witkiewitz, K., Athamneh, L. N., Kuhlemeier, A. (2024). Recovery from alcohol use disorder: Reinforcer pathology theory, measurement, and methods. *Alcohol Clin Exp Res*., (Hoboken), 48(9), 1626-1636; Brillhart, R. (2023). Recovery- and sobriety-support groups in a music community: An ethnographic study of Phish, the Phellowship, and the sensorium of sobriety. *J Subst Use Addict Treat*., Nov;154:209120. doi: 10.1016/j.josat.2023.209120. PMID: 37451518.

For the past quarter century, addiction field leaders have advocated extending acute care models of clinical intervention to models of sustained recovery management nested within larger recovery-oriented systems of care.[323] Achieving such a shift would allow addiction treatment and recovery support service programs to increase attention to the potential for personal and family flourishing within the experience of addiction recovery.

## Conclusion

Recovery flourishing is a global state of health, an elevated level of social functioning, and a heightened personal/family experience of meaning and purpose. This experience/state/practice is best viewed as a progressive process of growth within, and increasing balance between, multiple life domains. Recovery flourishing emerges via diverse pathways of experience, shares many common qualities, but also unfolds in many yet to be identified varieties across diverse populations and cultural contexts.

Addicted people die of addiction, but they also die from a lack of hope fed by cultural pessimism about the prospects of long-term recovery—deaths of low expectation. Where is the source of recovery hope when public survey responses reveal a definition of recovery as people "trying to stop using alcohol and other drugs" rather than achieving such, when popular media is regularly filled with accounts of celebrity relapse and return to "rehab", when the most visible faces of addiction treatment are those with untold numbers of treatment admissions, and when so many people in long-term recovery are hidden behind a wall of anonymity? Recovery pessimism is the lie that must be forever expunged from cultural consciousness. The reality, revealed by a growing body of scientific research and legions of people putting a public face and voice on recovery, is that: 1) sustained SUD remission is a widespread phenomenon—the normative outcome for substance use disorders,[324] 2) SUD remission is often

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[323] Coon, B. (April 8, 2025). *5 Year Continuing Care System for High Severity, Complexity, and Chronicity SUD's: Clinical Targets, Methods, and Increments of Time*. (2022 monograph). RM/ROSC Library of the William White archives, Chestnut Health Systems; Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, 4(1), 45-55.; DuPont, R. L., Compton, W. M., & McLellan, A. T. (2015). Five-year recovery: A new standard for assessing effectiveness of substance use disorder treatment. *Journal of Substance Abuse Treatment*, 58, 1-5; 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. L. (2008b). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[324] Craft, W. H., Tegge, A. N., Keith, D. R., Shin, H., Williams, J., Athamneh, L. N., Stein, J. S., Chilcoat, H. D., Le Moigne, A., DeVeaugh-Geiss, A., Bickel, W. K. (2022). Recovery from opioid use disorder: A 4-year post-clinical trial outcomes study. *Drug Alcohol Depend*., May 1;234:109389. doi: 10.1016/j.drugalcdep.2022.109389. Erratum in: Drug Alcohol Depend. 2022 Dec 1;241:109687. doi: 10.1016/j.drugalcdep.2022.109687. PMID: 35287034; Day, E., Manitsa, I., Farley, A., Kelly, J. F. (2024). The UK National Recovery Survey: nationally representative survey of people overcoming a drug or alcohol problem. *BJPsych Open*, Mar 14;10(2):e67. doi: 10.1192/bjo.2023.654. PMID: 38482691; PMCID:

accompanied by enhancements in global health and social functioning,[325] and 3) many people in SUD remission/recovery go on to experience lives of significant achievement, community contribution, and personal meaning and fulfillment,[326] the true prevalence of which is limited by the lack of definitive studies of recovery flourishing. Recovery flourishing will increase when the dominant cultural narrative about the likely course of addiction, the prevalence of recovery, and the potential of recovering people as community assets are fully recognized at personal, public, and policy levels.

The growing awareness of the existence of flourishing within the experience of addiction recovery has potentially important implications for affected individuals and families, service providers, local communities, and drug policy makers. The author has seen 'living proof' that individuals and families can rise above addiction to first experience deliverance from that condition and to then draw strength from surviving that adversity to reach a level of achievement and meaning that might have otherwise not been possible. It is hoped that the observations shared about such transformations will inspire increased study of this phenomenon and its potential recovery support implications and applications. It is critical that we as a field understand and capitalize on transformational processes that turn addiction-related adversities into recovery challenges that elicit previously untapped personal, family and community strengths.

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[325] Manning, V., Garfield, J. B. B., Lam, T., Allsop, S., Berends, L., Best, D., Buykx, P. Room, R. & Lubman, D. L. (2019). Improved quality of life following addiction treatment is associated with reductions in substance use*. J Clin Med*., Sep 6;8(9):1407. doi: 10.3390/jcm8091407 PMCID: PMC6780566, PMID: 31500211

[326] Eddie, D., White, W. L., Vilsaint, C. L., Bergman, B. G. & Kelly, J. F. (2021). Reasons to be cheerful: Personal, civic, and economic achievements after resolving an alcohol or drug problem in the United States population. *Psychology of Addictive Behaviors*, 35(4):402-414. doi: 10.1037/adb0000689.

David Best, Chris Budnick, Tom Coderre, Brian Coon, Dr. John Kelly, Dr. Wayne Kepner, Boyd Pickard, Jason Schwartz, Bill Stauffer, and Matt Statman.

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## Appendix A: Glossary of Terms

**Addiction**: Substance use disorders characterized by the highest severity, complexity and chronicity.

**Alcohol and other drug problems:** the spectrum (clinical and subclinical) of harmful patterns of alcohol and other drug use.

**Flourishing** (in the context of addiction recovery): an exceptional level of global (physical/cognitive/emotional/relational/spiritual) health, life meaning and purpose, and social/cultural contribution experienced within the constraints of one's limitations and life circumstances.

**Post traumatic growth:** enhancement of global health and personal strengths emerging in aftermath of weathering adversity/trauma.

**Recovery:** Resolution of a substance use disorder via sustained remission (abstinence or deceleration of use to subclinical levels) plus enhancement of physical/ emotional/spiritual health, social functioning, and repair of the person-community-relationship.

**Remission:** sustained deceleration or cessation of drug use to the point that the diagnostic threshold for a substance use disorder is no longer met.

**Resilience:** protective measures / guardrails (e.g., drug deceleration or cessation) taken by individuals at high risk of addiction and substantial drug exposure to reduce risk of progression from drug use to development of a substance use disorder.

**Resistance:** conscious drug refusal or limitation of drug exposure by individuals or groups at high risk for addiction as a device of self-protection or assertion of personal/cultural protest/sovereignty.

**Risk minimization:** conscious changes in drug use consumption patterns to reduce likelihood of drug-related injury to self (morbidity and mortality) and others by individuals who may or may not meet SUD diagnostic criteria

**Substance use disorder:** Medical conditions that meet diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders) of the American Psychiatric Association and that collectively share loss of control over drug use decision making and significant impairment in personal health and functioning.

**Appendix B: Source Citations for Table 1**


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# THE RECOVERY READINESS INDEX
# FIRST DRAFT (2-18-2026)

**There are multiple catalysts for recovery initiation. Each item below in the Recovery Readiness Index (RRI) has been referenced in the addictions literature or drawn from the author's personal/clinical experience as a potential motivating factor for recovery initiation. This first draft is being made available for review and comment prior to formal studies that can develop psychometrics for this new assessment tool. No benchmarks predicting recovery readiness using scores from this instrument are possible until such studies are completed. In the interim, the instrument may be used as a self-assessment inventory or a guide for recovery readiness discussions facilitated by addiction counselors, recovery coaches, and other helping professionals.**

**Key questions to be explored: Is there a quantitative tipping point (number of agree responses) that predicts successful recovery initiation and stabilization? Are there particular items or combinations of items most predictive of such success? If so, what service and support interventions might strengthen such dimensions for all those needing or seeking recovery? How do such factors differ across diverse populations (e.g., primary drug, youth, elderly, women, BIPOC, LGBTQ+, etc.), across levels of problem severity/complexity/chronicity and recovery capital, and across diverse cultural contexts?**

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## The Recovery Readiness Index

**Rate each item to the degree it reflects your present beliefs, feelings, or experience using the following scale: 1) agree 2) disagree, or 3) not sure**

1. ___My alcohol and/or other drug use is not as pleasurable for me as it once was. (Depreciation of Drug Reward)

2. ___ The intensity of my physical cravings for drugs are more than they used to be. (Craving Amplification)

3. ___ I no longer have control over myself or my drug use decisions. (Loss of Control)

**SCALE: 1) agree 2) disagree, or 3) not sure**

4. ___ I feel my identity (who I am and hope to be) has been spoiled in my own eyes and in the eyes of others (Spoiled Identity; Despair).

5. ___The consequences of my drug use are too great; if I keep going this way, I will lose everything. (Pain Quotient)

6. ___I have so much to lose if my drug use does not change. (Risk Awareness)

7. ___ I have wondered what my life would be like if I did not use drugs. (Recovery Rumination/Visualization)

8. ___ I am trying to educate myself about recovery through reading, videos, or talking with people in recovery. (Recovery Education)

9. ___I have tried periods of not using to see what that would be like or to escape pressure that I was under. (Sobriety Sampling)

10. ___I feel guilt/shame/self-disgust/fear related to things I have done and failed to do because of my drug use. (Traumatic Discontent)

11. ___I feel totally alone, like I have burned all my relationship bridges. (Collapse of Enabling System)

12. ___I have had a profound experience (vision, revelation, epiphany, awakening) that has changed how I view myself, my drug use, and the world. (Transformational Change; Spirituality)

13. ___I feel like I am at a turning point or critical crossroad in my life (Turning Point)

14. ___I have family members, friends, or acquaintances who no longer use drugs (Recovery Social Support)

15. ___I don't want to live this way anymore; I am getting too old for this way of life (Maturing Out; Retirement Aspirations)

16. ___There are people in recovery who I know and admire (Recovery Belief)

17. ___A person in recovery has personally encouraged me. (Wounded Healer / Recovery Carrier Exposure)

18. ___I think recovery might be possible for me. (Recovery Optimism)

19. ___I understand the reasons for my addiction and what I need to do to recover. (Sensemaking / Story Reconstruction)

**Scale: 1) agree 2) disagree, or 3) not sure**

20. ___There are important things I still want to do with my life (Meaning and Purpose).

21. ___I think my experience could be of help to others. (Helper Principle)

22. ___I have access to sources of help to recover. (Helping Resources)

23. ___I have been weighing the pros and cons of continued drug use. (Pro Con Analysis)

24. ___I have found a community of recovering people who have welcomed me and with whom I identify. (Recovery Community)

25. ___I feel pressure related to my family or parenting responsibilities to cease my drug use. (Family Responsibility)

26. ___My family has sought help related to my drug use and its effects on them. (Family Recovery).

27. ___I am under pressure from my family, employer, or the courts to cease my drug use. (External Pressure)

28. ___I have experienced a recent (past year) health/life-threatening problem resulting from my drug use. (Health Threat)

29. ___ I am worried that the damage drugs have done or could do to my body/mind may be permanent. (Health Fear)

30. ___I feel like an imposter that no one really knows and that I could be exposed at any moment. (Imposterhood)

31. ___Some days I feel like I am going insane. (Fear of Insanity)

32. ___I have recently relocated to get a fresh start. (Geographical Change; Culture of Addiction Disengagement)

33. ___I am in a new relationship that is supportive of my recovery. (Partner Support)

34. ___I have new interests in drug-free activities. (Drug-free Pleasure)

35. ___I am involved in volunteer service activities (helping others) in my community. (Community Service)

**Scale: 1) agree 2) disagree, or 3) not sure**

36. ___I will do whatever it takes as long as it takes to be free. (Persistence; Recovery Commitment)

37. ___ I am taking concrete steps to detach myself from the “people, places, and things” associated with my drug use. (Cutting Ties)

38. ___I plan on proving a lot of people wrong by getting free of drugs and making something of myself. (Personal Defiance)

39. ___Drugs have been used as a weapon of exploitation and subjugation of my culture and community. (Cultural Consciousness)

40. ___I think of my desire for recovery could be thought of as an act of resistance/rebellion and an act of personal/cultural revitalization. (Cultural Activism)

41. ___I am seeking professional treatment for my alcohol and/or other drug problems. (Help-seeking)

42. ___I will be subjected to drug testing for the foreseeable future. (Drug Test)

43. ___I am now taking prescribed medication to support my recovery (Medication Support)

44. ___ I have someone (sponsor, counselor, recovery coach, good friend) I can regularly talk to about my recovery. (Recovery Guide)

45. ___ My circumstances have improved / I am hopeful about my future. (Hope)

46. ___ I am convinced that I can do this (recover). (Recovery Confidence)

47. ___ I am aware of diverse pathways and styles of recovery initiation and maintenance (Recovery Pathways)

48. ___ I have non-drug activities in which I am intensely involved. (Alternative Passion/Pursuit)

49. ___ I possess mementos that remind me of my past addiction and my commitment to recovery. (Recovery Mementos)

50. ___ My present living arrangements are secure and supportive of recovery. (Living Arrangements)