Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches

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Preface

Preface by Dr. Michael Flaherty and Charlie Bishop, Jr. (Include connection of chronic disease model and prevention)

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Introduction

A long-tenured addictions counselor sheepishly shared that he was leaving the field—that it was getting harder and harder for him to feel good about what he was doing. He elaborated as follows, "Something got lost on our way to becoming professionals—maybe our heart. I feel like I'm working in a system today that cares more about a progress note signed by the right color of ink than whether my clients are really making progress toward recovery. I feel like too many treatment organizations have become people and paper processing systems rather than places where people transform their lives. Too much of our time is spent fighting for another day or a couple of extra sessions for our clients. I'm drowning in paper. We're forgetting what this whole thing is about. It's not about days or sessions or about this form or that form, and it's not about dollars; it's about RECOVERY!"[1]

At a recent gathering of Native American leaders, speaker after speaker referenced the disconnection between the world of addiction treatment and the cultural life within Native communities. In their culture, there is no separation between the individual, the family and the tribe. All have suffered wounds from alcohol and other drugs, and all need recovery processes that reflect an understanding of their historical trauma and current circumstances. The speakers advocated healing the community so that the community could in turn serve as a healing sanctuary for individuals and families.

With great sadness, the counselor reflects, "The kids who come here do so well while they are in treatment, but so many of them relapse in the days and weeks following their discharge. We bring them back to treatment and they seem to do well again but often repeat the relapse pattern when they go back home. How can they do so well in treatment and so poorly in their natural environments?"

An A.A. old-timer laments the lost service ethic among local groups in his community and recounts times when Twelve Step calls were something more than telling someone to call the local detox center. He feels that the service ethic has weakened in tandem with the expansion of addiction treatment.

The growing interest in recovery research, the advent of recovery coaches and recovery support centers and the expanded funding for peer-based recovery support

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[1] Many reviewers responded to this first paragraph just as audiences do around the country when we present this material. As one reviewer noted, "The treatment system across the nation is being strangled in its own red tape."

services all reflect efforts to recapture the field's lost recovery focus and reconnect the treatment experience to recovery and treatment institutions to the larger communities in which they are nested. There are increasing calls to shift addiction treatment from ever-briefer episodes of acute stabilization to a more global process of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000). This would extend the role of the addiction counselor beyond the earliest stages of recovery initiation to the more complex processes of recovery stabilization and maintenance within the natural environment of each client and family. A critical aspect of that process involves connecting recovering individuals and families to local recovery support groups and communities of recovery as well as nurturing the development of such supports where they do not yet exist (White, Boyle & Loveland, 2002).

At the same time, many communities of recovery are experiencing a revival in service work as new recovery advocacy groups, in the language of the Connecticut Community of Addiction Recovery, "organize the recovery community's ability to care." Such organizations are acting on the belief that the recovery community has a responsibility to reach out to treatment organizations as well as to individuals and families who are entering and leaving treatment. These recovery advocacy groups are discovering a growing vanguard of people in long-term recovery who are responding with their time, their talents, their financial resources, and, most importantly, their stories to help those whose current suffering was once their own.

This monograph explores how to best facilitate this connection between the worlds of addiction treatment and addiction recovery. It is divided into six topical discussions:

1) The historical forces that are sparking a re-evaluation of the design of addiction treatment in the United States,
2) A review of the scientific evidence supporting the shift from an exclusively acute care (AC) model of treatment to a model of sustained recovery management (RM),
3) The growth, current status and growing diversity of American communities of recovery,
4) Strategies for building relationships between treatment organizations and local communities of recovery,
5) Procedures that can be used to assertively and effectively link clients to recovery support groups, and
6) Integrating this linkage process within a larger menu of post-treatment recovery support services.

This monograph is a follow-up to our recently released monograph, *The Varieties of Recovery Experience* (posted at http//:www.glattc.org). Our work on these recovery-themed papers began in 1998 with the establishment of the Behavioral Health Recovery Management Project funded by the Illinois Department of Alcoholism and Substance Abuse. Subsequent support has been provided by the Great Lakes Addiction Technology Transfer Center and (for this latest monograph) the Institute for Research, Education and Training in Addictions (IRETA). We extend a special thanks to Dr. Michael Flaherty and Charlie Bishop Jr. for their guidance on the development of the content of this essay and for their helpful reviews of early drafts. We would also like to thank the following

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A Brief Note on Language

The groups in which people regularly meet for mutual support in their recovery from alcohol and other drug problems have gone by many designations (*self-help, mutual aid, peer support* and *recovery support*). In the following pages, the terms *recovery mutual aid groups* and *recovery support groups* will be used interchangeably to refer to these groups. The larger networks of people and activities in which support group meetings are imbedded are referred to as *communities of recovery*. The term *recovery community* is used to convey the whole of these increasingly diverse communities of recovery. The term *recovery support services* refers specifically to non-clinical (not requiring training in diagnosis and treatment) services that aid recovery initiation and maintenance, e.g., activities such as monitoring (check-ups), modeling, sharing, encouraging, coaching/advising, linking, advocating and organizing.

Historical Background: Toward a Recovery Paradigm

From Problem Conceptualization to Treatment Strategies: Cultures across the world have embraced widely divergent views of the origin of alcohol and other drug (AOD) problems. AOD problems and their resolution have been defined in religious terms (sin and redemption), spiritual terms (hunger for meaning and personal transformation), criminal terms (amorality/immorality and reformation), medical/disease terms (sickness and recovery), psychological terms (flawed thinking/coping and maturation), and socio-cultural terms (historical trauma/oppression and liberation/cultural renewal). These highly divergent approaches and their historical roots have been a subject of considerable debate (see Miller & Kurtz, 1994; Kurtz, 2002).

The question of which model is "true" or "works" is not a trivial one. The model choice dictates cultural/professional ownership of AOD problems—whether these problems belong to priests, judges, physicians, psychologists, addiction counselors or community activists. The chosen model dictates particular intervention philosophies and settings (whether the alcoholic is punished in a jail cell or counseled in a treatment center) and offers organizing metaphors for individuals and families impacted by AOD problems. All of the noted models begin with an understanding of the primary cause of AOD problems and then derive resolution strategies congruent with that understanding. This paper, in contrast, asks, "What if addiction treatment, addiction counseling and related recovery support services were designed, not on a particular view of the etiology of addiction, but on the lessons drawn from millions of people who have achieved long-term addiction recovery?"

Treatment, Recovery, Community: Modern addiction treatment came of age in the 1960s and 1970s as a community-based phenomenon. Programs of that era were birthed out of grassroots community advocacy efforts and held accountable to their founding visions through:

- representation of recovered and recovering people and their families on agency boards and advisory committees,
- recruitment of staff from local communities of recovery,
- vibrant recovery volunteer programs, and
- regular meetings between the treatment agency and the service committees of local recovery support fellowships.

Treatment agencies of this era, because of their reliance on local funding, were also accountable to local governments and allied service agencies. Through the processes of professionalization, industrialization and commercialization in the 1980s, most treatment programs ceased being community-based agencies and redefined themselves as businesses. In the process, they became less reliant on local funding, less accountable to local communities and less connected to local communities of recovery. Today, treatment institutions are vulnerable to the charge that they are disconnected from their founding roots—that treatment has become detached from the larger and more enduring process of recovery and disconnected from the physical and cultural contexts in which that recovery succeeds or fails (White, 2001a; White & Hagen, 2005).

The Varieties of Recovery Experience: Another category of influence on the process of linking people to communities of recovery is the growth and diversification of recovery support societies in the United States and around the world (Humphreys, 2004). The growth, geographical dispersion and longevity of Alcoholics Anonymous (A.A.) has positioned A.A. as the most visible recovery mutual aid fellowship in the United States. That said, there is a growing diversification of styles of Twelve Step recovery experience and a proliferation of explicitly religious and secular alternatives to Twelve Step programs. This growth and diversification of recovery support groups as well as the growing recognition of different styles of recovery initiation and maintenance require a greater level of knowledge and skill for those linking individuals to post-treatment recovery support services (White & Kurtz, 2005). It also requires understanding the difference between linking a client to recovery support meetings and linking a client to the larger community of recovery within which such meetings are imbedded (Balmer, personal communication, 2006).

Emerging Movements: There are two emerging movements that, by their success or failure, will shape the future of addiction treatment and recovery in America. The first is a treatment renewal movement. Led by front line service providers from across the country, the goals of this movement include reconnecting treatment to the process of long-term recovery and rebuilding relationships between treatment organizations, local communities and local recovery support groups (White, 2002). A second movement, the new recovery advocacy movement, rose in reaction to the restigmatization, demedicalization and recriminalization/penalization of AOD problems in the 1980s and 1990s. This movement has been led organizationally by a coalition of the Faces and Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Johnson Institute, the Legal Action Center, and (until recently) the Center for Substance Abuse Treatment's Recovery Community Support Program.INSERT FOOTNOTE.ON YEAR OS SHIFT FROM ADVOACY TO SUPPORT The goals of this movement include reaffirming the reality of long-term addiction recovery, celebrating the legitimacy of multiple pathways of recovery, enhancing the variety, availability, and quality of local/regional treatment and recovery support services and transforming existing

treatment businesses into "recovery-oriented systems of care" (White, 2000; White & Taylor, in press).

Toward a Recovery Paradigm: Something is shifting in the behavioral health arena.   Pathology and intervention paradigms are yielding to an emerging recovery paradigm in both the addictions and mental health fields (White, 2004a, 2005; White, Boyle, Loveland, 2004; Anthony, Gagne, & White, in press). The earliest calls for this reconnection of treatment and recovery came from tenured addictions professionals (See Zweben, 1986; Morgan, 1995, a,b; Else, 1999), a new generation of recovery advocates (e.g., Don Coyhis, Bev Haberle, Bob Savage, Philip Valentine), leading research scientists (McLellan, Lewis, O'Brien & Kleber, 2000), and state and federal policy makers (See http://www.dmhas.state.ct.us/recovery.htm and http://alt.samhsa.gov/news/NewsReleases/040303fs_atr_facts.htm).

Implications for the Addictions Counselor and Recovery Coach: For those involved in the face-to-face work of providing addiction counseling and recovery support services, this shift toward a recovery paradigm is pushing a(n):

- greater focus on what happens BEFORE and AFTER primary treatment,
- transition from professional-directed treatment plans to client-developed recovery plans (Borkman, 1997)(See Sidebar),
- greater emphasis on the physical, social and cultural environment in which recovery succeeds or fails (e.g., shift from clinic-based aftercare to community-based continuing care)(Donovan, 1998),
- integration of professional treatment and indigenous recovery support groups (White & Sanders, 2004),
- increased use of peer-based recovery coaches (guides, mentors, assistants, support specialists) (White, 2004b), and an
- integration of paid recovery coaches and recovery support volunteers within interdisciplinary treatment teams.

How Recovery Plans (RP) Differ From Treatment Plans (TP)
1.The RP is developed, implemented, evaluated and refined by the client, not the treatment professional.
2.The RP is based on a partnership/consultation relationship between professional and client rather than an expert-patient relationship.
3.The RP is broader in scope, encompassing such domains as physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality, in addition to the resolution of AOD problems.
4. The RP consists of a master plan of long-term recovery goals and a weekly action plan of steps that will mark progress toward those goals.
5. The RP emphasizes drawing strength and strategies from the collective experience of others in recovery.
Source: Borkman, T. (1997) Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment* 15(1), 37-42.

This shift to a recovery paradigm is not without its sources of resistance and potential pitfalls. The obstacles that slow this shift are:

- conceptual (difficulty shifting from problem-focused to solution-focused thinking; difficulty thinking outside the acute care intervention model),
- personal/professional (a perceived loss of professional pride/status/power by addiction professionals, hesitancy to acknowledge the experiential wisdom of the recovery community, and reluctance to accept indigenous healers as peers)(Schwartz and Bass, personal communications, 2006),
- financial (the lack of financing models for post-treatment support services),
- technical (lack of evidence-based recovery support service protocol),
- ethical (the absence of ethical codes to guide the delivery of peer-based recovery support services), and
- institutional (weak infrastructures of addiction treatment organizations, particularly the exceptionally high turnover of service roles in the addiction treatment field).

While these obstacles are significant, the greatest obstacle may well turn out to be the tendency for treatment representatives to declare that they are already "recovery-oriented" or to mask treatment as usual behind a new recovery-focused rhetoric.

Working through these obstacles are recovery advocates and visionary professionals who "get it" and are willing to be part of this recovery advocacy and recovery support movement. Some of you reading these words may not fully realize it, but you were born for this moment in time. Your personal and professional experiences to date have prepared you to play a leadership role within this window of opportunity within the history of addiction treatment and recovery in America. It is the hope of the authors that you and others will use our discussions here to develop a personal vision of the role that you could play in widening the doorways of entry into addiction recovery and in enhancing the quality of life of people in recovery.

Scientific Background: Post-Treatment Outcomes, Role of Continuing Care, Role of Recovery Mutual Aid Participation, Importance of Post-Treatment Check-ups and Support

> *If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients.* Dr. Tom McLellan, 2002

The shift to a recovery paradigm is propelling the call for non-clinical alternatives to treatment, early identification and recovery engagement services, in-treatment recovery support services to increase successful treatment completion (now only about 50% of those admitted)(SAMHSA, 2002), and post-treatment monitoring and recovery support services. This paper focuses on the latter of these changes. To bolster our

argument for post-treatment recovery support services, we offer the following propositions.[2]

The need for post-treatment check-ups and recovery support services intensifies as problem severity increases and recovery capital decreases. (*Recovery capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery)(Granfield & Cloud, 1999). Not everyone with an AOD problem needs professional treatment or prolonged post-treatment continuing care. Many individuals with AOD problems resolve these problems without professional assistance, without involvement in recovery support groups, or through brief professional intervention. Those who require a larger dose, intensity and duration of professional and peer support services to resolve these problems are characterized by greater personal vulnerability (e.g., family history, age of onset, developmental victimization), greater problem severity, greater problem complexity (e.g., presence of co-occurring medical/psychiatric illness), and fewer family and social supports for long-term recovery (White, 2005). The increased representation of clients entering treatment with multiple personal/family/environmental problems (and complex histories of intergenerational transmission of those problems) calls for a longer period of service provision (but not necessarily longer lengths of stay in acute levels of treatment) and an expanded menu of clinical and non-clinical recovery support services.

Addiction treatment outcomes are compromised by the lack of sustained recovery support services. Reports of treatment effectiveness note robust effects. Treatment follow-up studies report an average full remission rate of one third and significant reductions in AOD use/AOD-related problems for most clients (Miller, et al, 2001). Hundreds of thousands of people have entered recovery through the pathway of professional treatment, but claiming that "treatment works" as a result of these findings masks the fact that the majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2003), with over half of all post-treatment lapses and relapses occurring within 30 days of discharge (80% within 90 days of discharge)(Hubbard, Flynn, Craddock & Fletcher, 2001).

Professionally-directed, post-discharge continuing care can enhance recovery outcomes, but only 1 in 5 clients actually receives such care (Ito & Donovan, 1986; Johnson & Herringer, 1993; Godley, Godley, & Dennis, 2001; Dennis, Scott, & Funk, 2003; McKay, 2001). Strategies proven to increase continuing care participation (e.g., the use of a brief orientation session on continuing care, behavioral contracting, telephone prompts)(Lash, 1998; Donovan, 1998) are not mainstream practices in addiction treatment. Nothing conveys more clearly the acute care model of addiction treatment in the United States than the "afterthought" status and virtually non-existent budgets supporting continuing care following "primary treatment." The self-contained, brief episodes of *assess, diagnose, treat, discharge, terminate the service relationship* that typify most addiction treatment would be unthinkable in the treatment of any other chronic medical condition.

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[2] This is not to say that linkage to recovery communities is something that should occur after treatment, but we do emphasize the role of such linkages on post-treatment recovery outcomes. We agree with several reviewers suggesting that this linkage could occur at the earliest point of service contact, including people who are on a waiting list for admission to treatment.

Participating in peer-based recovery support groups following treatment enhances long-term recovery outcomes, but without ancillary support, there is high attrition in such participation among those discharged from treatment (Mäkelä, Arminen, Bloomfield, Eisenbach-Stangl, Bergmark, Kurube, et al., 1996). Overall dropout rates in A.A. range between 35-68%, with most of this attrition occurring in the first weeks and months of contact with A.A. (Emrick, 1989). The two most recent and largest studies of attrition in A.A. participation during the year following discharge from treatment reported 41% and 40% dropout rates (Tonigan, Miller, Chavez, Porter, Worth, Westphal, Carroll, Repa, Martin & Tracy, 2002; Kelly and Moos, 2003). Active linkage (education about the potential value of peer support; facilitating direct connection to a person or specific group) can increase affiliation with a recovery mutual aid society (Weiss, et al 2000), but studies reveal most referrals from treatment professionals to mutual aid organizations are of the passive variety (verbal suggestion only) (Humphreys, et al 2004).

At present, the resolution of severe substance use disorders can span years (sometimes decades) and multiple treatment episodes before stable recovery maintenance is achieved (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Hristova, 2002). AOD drug dependencies resemble chronic disorders (e.g., type 2 diabetes mellitus, hypertension and asthma) in their etiological complexity, variable pattern of onset, prolonged course (with waxing and waning of symptom severity), treatment (sustained management rather than cure), and clinical outcomes (O'Brien & McLellan, 1996; McLellan, et al, 2000). To characterize addiction as a chronic disorder is not to suggest that recovery is not possible. There are millions of people in stable, long-term recovery from addiction (Humphreys, 2004; Dawson, et al, 2005), but the processes of recovery are more complex than what is portrayed to the public and to individuals and families entering treatment.

For many individuals, recovery sustainability is not achieved in the short span of time treatment agencies are currently involved in their lives. When addiction treatment agencies discharge clients following a brief episode of services, they convey the illusion that continued recovery is self-sustainable without further professional support. However, research data reveals that durability of recovery from alcoholism (the point at which risk of future lifetime relapse drops below 15%) is not reached until after 4-5 years of sustained remission (De Soto, O'Donnel, & De Soto, 1989; Jin, Rourke, Patterson, Taylor, & Grant, 1998). This recovery durability point is even longer for recovery from narcotic addiction (Simpson & Marsh, 1986; Hser, Hoffman, Grella, & Anglin, 2001). Such findings beg for models of sustained post-treatment check-ups and support comparable to the assertive post-treatment monitoring used in other chronic disorders, e.g., diabetes, heart disease, cancer. While the effects of acute treatment erode with time, the influence of the post-treatment environment increases. That is the environment we must niche within and remain within if we are truly interested in long-term recovery.

Addiction treatment has become the revolving door it was intended to replace. Addiction treatment was birthed in part to eliminate the "revolving door" through which alcoholics and addicts cycled through the criminal justice system and public hospitals. Addiction treatment programs have now become that revolving door. Today, 64% of persons entering publicly funded treatment in the United States have already had one or more prior treatments (22% with 3-4 prior treatments; 19% with 5 or more prior treatments)(OAS, 2005). Between 25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year, and 50% will be readmitted within 2-5

years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989; Simpson, Joe, & Broome, 2002).

There may be cumulative and synergistic effects resulting from multiple treatment episodes.   Long-term studies of clients treated for *substance dependence* in publicly funded programs reveal that the majority of those who achieve stable recovery do so after 3 to 4 episodes of treatment over multiple years (Anglin, Hser, & Grella, 1997; Dennis et al., 2005; Grella & Joshi, 1999; Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Hser, Grella, Chou, & Anglin, 1998). This raises the potential for linking and integrating multiple episodes to enhance their power to facilitate recovery initiation and maintenance.   According to studies of clients who relapse following discharge from primary treatment, the best predictor of recovery at five years following discharge is readmission to treatment (Mertens, Weisner & Ray, 2005). We need to find ways to strategically link these episodes of care to shorten addiction careers.

There is a growing body of evidence that enmeshing clients with high problem severity and low recovery capital within sober living communities can dramatically enhance long-term recovery outcomes (Jason, Davis, Ferrari & Bishop, 2001). A just-completed study compared the post-treatment recovery of individuals discharged from addiction treatment who were randomly assigned to either an Oxford House (one of the 1,200 Oxford Houses in the U.S.) or to traditional post-treatment "aftercare" (access to outpatient continuing care groups). The Oxford House members had less than half the rate of substance use, twice the monthly income, and a third of the incarceration rate of those assigned to traditional aftercare (Jason, Olson, Farrari & Lo Sasso, in press). This confirms earlier research on the importance of social support in the recovery process (Jason, Davis, Ferrari & Bishop, 2001; Humphreys, Mankowski, Moos & Finney, 1999) and suggests the need for greater linkage between addiction treatment institutions and this growing network of sober housing resources and sober social communities.

Conclusions: 1. *Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months and even years following treatment. 2. Post-treatment check-ups and support and assertive linkage to communities of recovery and other recovery support services can significantly enhance long-term recovery outcomes.* The findings of two recent Chicago studies stand as confirmation of these conclusions. Scott, Foss and Dennis conducted quarterly monitoring interviews of 1,326 clients over three years following an index episode of addiction treatment. Each client was categorized each quarter as 1) in the community using, 2) incarcerated, 3) in treatment, or 4) in the community not using. More than 80% of the clients changed status one or more times over the course of the three years (Scott, Foss & Dennis, 2005). In the second study, Dennis, Scott and Funk (2003) randomly assigned 448 individuals discharged from Chicago addiction treatment facilities to either a recovery management checkup (RMC) group (who received quarterly assessments, motivational interviewing, and, if needed, re-linkage to treatment services) or a control condition (quarterly status assessment only). The study found that those clients assigned to the RMC condition were more likely than those in the control group to return to treatment, to return to treatment sooner, and to spend more subsequent days in treatment. Most significantly, RMC participants experienced significantly fewer total quarters in need of treatment and were less likely to need treatment at 2 years follow-up.

The fragileness of post-treatment adjustment and evidence that multiple treatment episodes can precede stable recovery raise the possibility that addiction and treatment careers could be shortened and recovery careers extended if post-treatment check-ups and support were provided for substance use disorders in the manner they are being provided for other chronic conditions. In the long run, check-ups and support could:

- decrease the total number of acute treatment episodes required to achieve stable recovery,
- speed admission when such treatment is needed,
- enhance the dose of treatment and support services received, and
- hasten recovery stabilization and maintenance.

The studies of Dennis, Scott and colleagues (2003) and McKay's (2005) recent review of research on extended interventions confirm the potential importance of post-treatment monitoring (via recovery check-ups and active linkage to recovery supports). There is also evidence that such effects can be achieved using low-cost delivery formats (e.g., telephone-based check-ups and support) (McKay, 2005). The Connecticut Community of Addiction Recovery is currently being funded through the Connecticut Department of Mental Health and Addiction Services to pilot a telephone-based recovery support project for individuals who have been discharged from addiction treatment (Boffman, Fisher, Gilbert & Valentine, in press).

American Communities of Recovery: A Brief Introduction

A Long and Rich History: American recovery mutual aid societies predating A.A. include abstinence-based Native American religious and cultural revitalization movements (from the early 1730s), recovery circles of the Delaware Prophets, Handsome Lake Movements, Shawnee and Kickapoo Prophet movements, Indian Shaker Church, Native American Church and today's Wellbriety Movement, the Washingtonians (1840s), the Fraternal Temperance Societies (1850s-), the Ribbon Reform Clubs (1870s-), institutional support groups such as the Keeley Leagues and the Godwin Association (1870s-1890s), and such faith-based groups as the Drunkard's Club, the United Order of Ex-Boozers and the Jacoby Club (early 20th century) (White, 2001b). The history of A.A. has been marked by progressive growth in membership and groups, a diversification of A.A. member characteristics (by age, gender, ethnicity, sexual orientation, occupational background, etc.), and a growing diversity of styles of recovery within A.A. Adaptations of A.A.'s Twelve Steps began with Alcoholics Victorious (1948) and Narcotics Anonymous (1947, 1953), with alternatives to Twelve Step recovery programs growing rapidly in the last quarter of the twentieth century. .

Today, there are explicitly religious, spiritual (but not religious), and secular frameworks of addiction recovery in the U.S. Recovery support groups that emphasize the role of spirituality in recovery are represented by mainstream Twelve Step groups. Faith-based recovery support structures include Alcoholics Victorious, Teen Challenge, Alcoholics for Christ, Overcomers Outreach, Liontamers Anonymous, Mountain Movers, High Ground, Free N' One, Victorious Lady, Celebrate Recovery, Millati Islami and many local recovery ministries. Secular frameworks of recovery include Women for Sobriety (WFS), Secular Organization for Sobriety-Save Our Selves (SOS), Rational Recovery (RR), Men for Sobriety (MFS), Moderation Management (MM), SMART Recovery®, and LifeRing Secular Recovery (LSR) (White & Kurtz, 2005).

The major addiction recovery support groups are profiled in the Mutual Support Resources Guide that is posted at the Faces and Voices of Recovery (FaVoR) Website (http://facesandvoicesofrecovery.org/resources/support_home.php) and updated monthly by its developers, Drs. Ernie and Linda Kurtz. The FaVoR Guide catalogues both group-based mutual recovery support resources as well as Internet-based mutual recovery support resources. A summary chart of American addiction recovery mutual aid groups is displayed in table 1 in the Appendices, profiling each organization's founding date, membership size, philosophical orientation (secular, spiritual, religious), primary support format (face-to-face meetings or Internet-based support), and any special group focus. This table can serve as a tool in matching individuals to particular groups, but the most detailed info and web links to these groups can be found at the FaVoR web site.

Varieties and Commonalities: Studies of the recovery support structures reveal a wide diversity of catalytic metaphors that individuals use to understand and alter patterns of AOD use/problems. Metaphors are terms or phrases (crystallizations of ideas) that through analogy have the power to label and elucidate complex experience. Metaphors create breakthroughs in perception that enhance understanding of oneself and the self-world relationship. Catalytic metaphors are words/ideas that are so penetrating that they drive profound changes in personal behavior, personal identity and interpersonal relationships. There is, for example, a long history of the use of medical metaphors to understand addiction, e.g., *disease*, *illness*, *allergy*. Such constructs are "true" for many persons in the sense that they validate and make sense of otherwise incomprehensible and sanity-challenging experiences. They are metaphorically true to the extent that they provide a cognitive cornerstone through which some individuals can organize their movement from addiction to recovery via the processes of story reconstruction and storytelling (White, 1996).

The proposition that there are many pathways and styles of recovery rests on the existence of a wide range of words, ideas, metaphors and experiences that can serve as a catalyst for recovery initiation and maintenance. There are, for example, recovery programs that place the transcendence of self at the center of the recovery experience (e.g., A.A.'s powerlessness, acceptance, surrender; being "born again" in Christian recovery frameworks). But there are alternative frameworks that emphasize assertion of self (e.g., Women for Sobriety's "I have a drinking problem but it no longer has me. I am the master of it and I am the master of myself.") (Kirkpatrick, 1986, p. 166.) The variability of these frameworks is also seen when contrasting empowerment psychotherapies with models of alcoholism treatment that have tended to extol the importance of surrender and humility in the recovery process (Tiebout, 1949). Where most recovery frameworks focus on individual experience, frameworks arising within historically disempowered communities often use catalytic metaphors that focus on collective experience (historical trauma, genocide, cultural survival/renewal) as frameworks to understand the etiology of AOD problems and provide a rationale for rejection of alcohol and other drugs (e.g., The Red Road) (Coyhis, 2000).

Core ideas, organizational structures, meeting formats, communication styles, and daily recovery rituals differ considerably across the growing spectrum of American recovery mutual aid groups, but these groups also share many common characteristics. All recovery support groups:

- contain members who have transformed their lives using the group's key ideas and methods,
- provide an esteem-salvaging answer to the question, "Why me?" (How did I come to develop a problem in my relationship with alcohol and/or other drugs?),
- provide a rationale for dramatically altering one's pattern of AOD consumption,
- provide daily prescriptions for recovery maintenance, and
- enmesh each individual in a sanctuary of shared "experience, strength and hope."

A point crucial to this paper is that all recovery support groups have individuals who fully respond to their respective programs of recovery, individuals who partially respond, and individuals who do not respond at all (Morgenstern, Kahler, Frey & Labouvie, 1996). There are also individuals who initiate and sustain recovery within a particular mutual aid group, individuals who simultaneously attend different mutual aid groups (attending WFS and A.A. meetings concurrently), individuals who initiate recovery in one group and then shift affiliation to another group (e.g., movement from N.A. to A.A.), and individuals who initiate recovery in a group like A.A., then disengage from active participation in A.A., but successfully sustain long-term recovery (See White and Kurtz, 2005). There are individuals with severe AOD problems who experience natural recovery—the initiation and maintenance of recovery without professional treatment or involvement in a recovery mutual aid group (Tuchfeld, 1981; Biernacki, 1986, Granfield & Cloud, 1999).

So what do we make of all this? Given this diversity in styles of recovery initiation and maintenance, the best strategy is for each treatment program and addictions professional to develop a broad menu of recovery-focused ideas, activities, and mutual aid structures that can be offered to clients. Our job is not to coerce or convince clients that one particular framework of recovery is the best. Rather, it is to offer each client exposure to the successful pathways of recovery that others have used and to help each client find a framework and style of recovery that achieves a personal fit.

So what are the facts about recovery mutual aid groups in America? The following historically and scientifically grounded propositions constitute a good starting point.

1. Americans with severe alcohol and other drug problems have banded together for mutual support in recovery for more than 250 years (White, 1998, 2001ba or b?).
2. Alcoholics Anonymous, due to its membership size, wide geographical dispersion, wide adaptation to other problems, and organizational longevity has established itself as the standard by which other recovery mutual aid groups are evaluated (Room, 1989; Kurtz & White, 2003).
3. Participation in recovery mutual aid groups following addiction treatment enhances long-term recovery outcomes (Emrick, Tonigan, Montgomery & Little, 1993, Fiorentine, 1999; Humphreys, et al, 2004).
4. In spite of allegations to the contrary, recent studies confirm A.A. affiliation and recovery rates for women, people of color, young people, and people with co-occurring psychiatric disorders (including those on medication)

comparable to those reported for general A.A. membership (Humphreys, Mavis, & Stoffelmayr, 1994; See White & Kurtz, 2005 for a review).

5. There are alternatives to A.A. and Twelve Step programs that offer different goals (e.g., moderation-based groups), philosophies (e.g., explicitly religious and secular groups), and recovery initiation and maintenance strategies (Humphreys, 2004; White & Kurtz, 2005).

6. Most of what we know from the standpoint of science about recovery support groups is based on studies of A.A., although studies of other recovery support groups have increased in the past 25 years (Humphreys, 2004).

7. Studies of recovery mutual aid groups reveal evidence of a dose effect (recovery stability increases with number of meetings attended) (Humphreys, Moos & Cohen, 1997; Chappel, 1993) and an intensity effect (recovery stability increases with broader pattern of participation (e.g., applying concepts to daily problem solving, reading recovery literature, sober socializing, service work) (Montgomery, Miller & Tonigan, 1995; Humphreys, Moos & Cohen, 1997).

8. Completion of addiction treatment AND participation with recovery mutual aid groups is more predictive of long-term recovery than either alone (Fiorentine & Hillhouse, 2000).

9. All recovery mutual aid groups experience individuals who fully respond, individuals who partially respond, and individuals who do not respond at all to their program (Morgenstern, Kahler, Frey, & Labouvie, 1996).

10. Individuals may initiate recovery through one framework and then shift to another framework to maintain that recovery (e.g., African American women shifting from A.A./N.A. for recovery initiation to use of the church as their primary source of support for recovery maintenance) (White, Woll, & Webber, 2003).

Embracing these propositions calls for treatment agencies and treatment professionals to broaden their treatment tenets to embrace a philosophy of choice, strengthen their relationships with diverse communities of recovery and enhance and individualize their strategies for linking clients to particular communities of recovery (Woll, personal communication, 2006).

Unanswered Questions: The many problems unique to the study of recovery mutual aid groups leave many unanswered questions. Additional research is needed to enhance our ability to more effectively match particular individuals to particular recovery support groups. A short sampling of critical unanswered (even unasked) questions include the following:

1. Are the findings from studies of A.A. applicable to other Twelve Step groups (e.g., N.A./C.A.) and to alternative recovery support structures?

2. What are the patterns of long-term affiliation (or disaffiliation) with A.A., and how are these patterns similar or different for other recovery support groups?

3. Does exposure to a moderation-based support group shorten addiction careers for some individuals by accelerating their commitment to sobriety following failed efforts to maintain moderation guidelines?

4. Which clinical practices in addiction treatment lead to the highest rates of affiliation with recovery support groups following treatment?
5. What are the needs of people in advanced stages of addiction recovery?
6. What factors contribute to relapse after 5-20+ years of continuous recovery?
7. What role does participation in the recovery community outside of meeting attendance play on the stability and quality of long-term recovery?

Mutual Aid Critics: Criticism of recovery mutual aid groups has generally focused on A.A. There is almost a cottage industry of A.A. and Twelve Step critics who contend that 1) A.A. is not successful or is successful with only certain types of alcoholics, 2) A.A.'s religious language keeps many alcoholics from seeking recovery, 3) People become too dependent on A.A. (charges that A.A. is a cult that creates "Twelve Step Zombies"), 4) A.A.'s reliance on a Higher Power undermines personal responsibility and development of internal strengths, 5) A.A. ignores environmental factors that contribute to alcohol problems, and 6) A.A.'s political influence has retarded the scientific advancement of the alcoholism treatment field and contributed to clinical rigidity (reviewed in White, 1998).

Perhaps more troublesome is the allegation in print (e.g., Gilliam, 1999; Fransway, 2000) and on the Internet (e.g., www.aadeprogramming.com or http://health.groups.yahoo.com/group/12-step-free/) that individuals have been harmed by affiliation with A.A. and related recovery support groups. This raises important and currently unanswered (from the standpoint of science) questions: are there individuals for whom all or particular mutual aid groups are contraindicated (individuals who are at high risk of being injured by their experiences within a mutual aid group)? If so, what are the recognizable characteristics of such groups, the characteristics of the individuals most vulnerable to injury, and the nature of the injuries they could experience? Until such questions can be fully answered, we recommend promoting a choice philosophy and monitoring each client's ongoing responses to recovery support group participation.

The Choice Philosophy: Steps that addiction treatment programs can take to actualize a philosophy of choice are outlined below.

Actualizing the Choice Philosophy

- Counselors, recovery coaches and volunteers represent the diversity of pathways and styles of recovery.
- Counselors and recovery coaches are knowledgeable about the full spectrum of religious, spiritual and secular recovery support groups and can fluently express the catalytic ideas used within each of these frameworks.
- Counselors and recovery coaches are aware of patterns of co-attendance (concurrent or sequential participation in two or more recovery support structures, e.g., co-attendance at WFS and A.A. meetings, N.A. participation with later transitioning to A.A. as one's primary recovery

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> support structure).
> - Clients/families are educated about the variety of recovery experiences and the legitimacy of multiple pathways and styles of recovery.
> - Informational materials, lectures and structured exercises in counseling represent the scope of recovery support options, e.g., posting all local recovery support meeting schedules on the treatment agency website and facility bulletin boards, giving each client a wallet card with the central contact numbers of local recovery support groups, profiling local recovery support groups in agency/alumni newsletters.
> - Client choice is respected; clients are not demeaned or disrespected for the recovery support strategies they choose; clinical strategies involve motivational interviewing principles and techniques rather than coercion and confrontation.
> - Counselors and recovery coaches are encouraged to self-identify and bring to supervision negative feelings about an alternative pathway of recovery used by a client.

Choice and the Stages of Recovery: One of the problems in implementing a choice philosophy for the addictions counselor or recovery coach is reconciling the philosophical and therapeutic value of choice with new evidence on the neurological impairments that lead to impaired choice-making abilities of individuals in active addiction and early recovery (Dackis & O'Brien, 2005). The question is, how does one distinguish authentic choice from what A.A. calls "stinkin' thinkin'", what Rational Recovery calls the addictive voice or "Beast," what Secular Organization for Sobriety refers to as the "lizard brain," what LifeRing Secular Recovery calls the "addict self" (versus the "sober self"), and what Christ-centered recovery groups refer to as the "voice of the Devil?" Given the dichotomy between the sober self and the addicted self, the question we have is, "who's really choosing: Dr. Jekyll or Mr. Hyde?" Some would frame this as separation of what each client wants/needs from what his or her disease wants/needs.

This dilemma can be partially reconciled by viewing recovery as a progressive rehabilitation of the will—the power to reclaim personal choice (Smith, 2005). What this means at a practical level is that the first day of detox may not be the best time to rely exclusively on client choice. Without rehabilitation of the power to choose and an encouragement of choice, we get, not sustainable recovery, but superficial treatment compliance. The application of this philosophy of choice will also need to be nuanced when immaturity, acute psychiatric symptoms, drug impairment and impaired ability to read social cues may severely limit choice generation, choice analysis and capacity to stick with any personal resolution. In such cases, we must carefully plot a path between complete autonomy (total choice and clinical abandonment) and paternalism (no choice).

Creating Informed Consumers: A philosophy of choice is viable only with persons who have the neurological capacity for decision-making, who believe they have the right to make their own choices and who are aware of and can evaluate available service and support options. Creating informed, assertive consumers of addiction treatment and recovery support services can be enhanced by: 1) affirming the service

consumer's right to choose, 2) distributing and reviewing consumer guides on treatment and recovery support services published by recovery advocacy organizations, 3) teaching service consumers how to recognize quality services, 4) encouraging consumers to visit service options before making a decision (versus taking whatever is offered them), and 5) defining the criteria by which the client and service specialist will know if participation in a particular group is working or not working (Bev Haberle, personal communication).

      <u>Choice and Limited Resource Alternatives:</u> Another obstacle to implementing a choice philosophy is the limited recovery support options available within many local communities. Altering that situation requires moving from a clinical perspective to a recovery community development perspective. Recovery options are expanding, clients are using these options (either alone or in patterns of co-involvement with one or more support groups), and progressive treatment organizations are playing a role in nurturing the development of expanding recovery support resources. We will describe shortly how this can be achieved.

Building Relationships between Treatment Organizations and Local Communities of Recovery

      An emphasis on changing social networks to be conducive to recovery could heighten clinical effectiveness and prevention efforts within communities.
-Constance Weisner, Helen Matzger & Lee Ann Kaskutas, 2005

      More work is needed to strengthen the ability of addiction treatment…to link patients to self-help programs and support their on-going participation in them.
James McKay, 2005

      …interventions should focus on enhancing continuation in AA and on identifying other mutual aid groups that may provide similar benefits. –Rudolf & Bernice Moos, 2005

      Relationships between treatment organizations and recovery support groups have changed dramatically over the past 40 years. As noted earlier, the pattern of collaboration that once existed between treatment agencies and local mutual aid groups dissipated in the professionalization of addiction counseling and the industrialization of addiction treatment. The evidence presented earlier in this paper suggests the need to re-link addiction treatment to indigenous communities of recovery.

      <u>Linkage Philosophy:</u> There are three critical points in shaping a philosophy of linkage between treatment agencies/professionals and recovery mutual aid groups. The first is that professional treatment can be viewed as an adjunct to recovery mutual aid groups, rather than seeing such groups as an adjunct to treatment. Secondly, recovery mutual aid groups can serve as an alternative to professional treatment (Humphreys & Moos, 2001; White & Kurtz, 2005). Let us state again recent findings that participation in professional treatment and recovery support groups generates better long-term recovery outcomes than participating in either professional treatment or recovery support groups alone (Fiorentine & Hillhouse, 2000). These findings are based on clinical studies of individuals who present to treatment with severe AOD problems and limited recovery

support networks. There are, however, situations where recovery mutual aid groups stand as an appropriate initial choice over admission to professionally-directed addiction treatment. This occurs when individuals present with lower problem severity and high recovery capital (internal and external recovery support assets). In this case, an individual could be referred to a recovery support group and their responses monitored to see if he or she can initiate and sustain recovery without the need for professional treatment. This alternative can potentially avoid the expense of treatment and the stigma and discrimination that can accompany diagnosis and treatment of a substance use disorder. Within this philosophical stance, addiction treatment is not the first line of response for AOD problems, but a safety net for those individuals who cannot resolve AOD problems through nonprofessional family and community supports.

A second point in this linkage philosophy is the need to respect the principles and guidelines recovery support groups have established to govern their relationships with outside organizations. Efforts must be made by the treatment agency to understand and abide by such principles as they differ from group to group. Twelve Step groups rely on codified traditions that govern their group life and their external relationships. A.A.'s Twelve Traditions, for example, would suggest that addiction treatment agencies not:

- refer individuals to closed A.A. meetings who do not meet A.A.'s requirement for membership as set forth in Tradition Three ("The only requirement for A.A. membership is a desire to stop drinking.")
- involve A.A. service committees in matters unrelated to carrying a message of hope to alcoholics (Tradition Five: "Each group has but one primary purpose—to carry the message to the alcoholic who still suffers.")
- use the A.A. name in any promotional material that would inadvertently convey A.A.'s endorsement of the treatment agency or that A.A. was affiliated with or a part of the treatment agency (Tradition Six: "An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.")
- offer financial contributions to A.A. (Tradition Seven: "Every A.A. group ought to be fully self-supporting, declining outside contributions.")
- entitle roles (e.g., "A.A. Counselor") with names that convey the professionalization of the A.A.'s service to still-suffering alcoholics (Tradition Eight: "Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.")
- solicit A.A.'s opinion on any outside issue or otherwise draw A.A. into any public controversy (Tradition Ten: "Alcoholics Anonymous has no opinion on outside issues, hence the name of A.A. ought never be drawn into public controversy.")
- violate the anonymity of any A.A. member by linking their full name and A.A. affiliation at the level of press, radio or film (Tradition Eleven: "Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.") (Alcoholics Anonymous, 1982[1]).

A third point is that groups claiming to be recovery support groups ought to also be held accountable by treatment facilities to certain basic standards, including the expectation that such groups be based on testable principles of personal change, are accountable for recovery outcomes, do not interfere with the medical treatment of its members, do not financially, sexually or emotionally exploit their members, and do not claim expertise for which they possess no education, training and experience (Nicolaus, personal communication, 2006). Recovery mutual aid group experiences are not universally positive, and some such experiences may be harmful. Professionals have a responsibility to understand the potential for such harm and injury, orient their clients to the potential risks as well as benefits of support group participation, link their clients to particular individuals and groups that have a reputation for integrity, and monitor each client's experiences within those groups that have been recommended. When a client is not experiencing positive benefits from their participation in a particular group or risks injury from such continued participation, then disengagement from that group and the exploration of alternative sources of recovery support are indicated and should be encouraged. Problems of attrition in recovery mutual aid groups are usually conceptualized as a failure of the individual, but such attrition should also be a source of feedback about and to the recovery mutual aid group.

A final point in this linkage philosophy is a reaffirmation of the earlier philosophy of choice that calls for respect for different relational styles of recovery and respect for the legitimacy of different recovery pathways (religious, spiritual, secular) and their respective support groups (White & Nicolaus, 2005). By relational style, we refer to how individuals in recovery relate or do not relate to others in recovery. There are acultural styles in which individuals recover without relationships with others in recovery, bicultural styles in which individuals have a balanced social network of people in recovery and "civilians" (those without addiction/recovery experience), and culturally enmeshed styles in which individuals are almost completely absorbed in relationships with other people in recovery (White & Kurtz, 2005). We recommend a linkage philosophy that includes tolerance for acultural styles of recovery (particularly for those with low problem severity and high recovery capital) as well as tolerance for very enmeshed styles of recovery. Persons with deep, prolonged involvement in cultures of addiction may require an enmeshed style of early recovery. There is recent evidence that these affiliation styles change for many people over the course of recovery (Kaskutas, et al, 2005).

Goals of Linkage Process: There are three primary goals for linking individuals in addiction treatment to recovery support groups and the larger communities of recovery: 1) to solidify recovery initiation (problem identification, recovery commitment, resolution of personal/environmental obstacles to recovery, beginning identity and lifestyle reconstruction), 2) to connect each individual/family to a community of recovered and recovering people with whom they can share their experience, strength and hope, and 3) to provide communal guidance for the transition from recovery initiation/stabilization to long-term recovery maintenance.

Linkage Principles: There are several scientifically and clinically grounded findings and principles that should guide the linkage of clients to recovery support groups.

- Assertive linkage (facilitating the connection between the client and a particular individual/group) is more effective than passive linkage (verbal encouragement) (Weiss, et al 2000).
- 40% of clients discharged from treatment do not participate in recovery support groups in the weeks and months following their discharge (Moos & Moos, 2005).
- Rapid entry into involvement with a recovery support group during treatment services generates better long-term recovery outcomes than delayed linkage (e.g., following treatment or at a period subsequent to treatment) (Moos & Moos, 2005).
- Broader patterns of recovery support group participation are more predictive of sustained remission than the more restrictive measure of meeting attendance (Montgomery, Miller & Tonigan, 1995; Humphreys, Moos & Cohen, 1997).
- The longer the participation in recovery support groups in the three years following primary treatment, the greater the probability of remission at 15+ years following treatment (Moos & Moos, 2005).
- There are high early dropout rates in recovery support group participation (in the 40-70% range)(Kelly & Moos, 2003; Moos & Moos, 2005).
- Sustaining and increasing recovery support group involvement over years 1-3 following treatment is associated with stable remission at subsequent follow-up (Moos & Moos, 2005).
- While some individuals disengage from recovery support groups after a period of recovery initiation and sustain stable remission (Kaskutas, et al, 2005), those who sustain recovery support group participation are more likely to be in remission at follow-up than those who disengage (Moos & Moos, 2005).

These findings suggest an assertive linkage process that begins immediately upon treatment initiation, is monitored over time and includes ongoing coaching for recovery support group participation and, when indicated, re-linkage to past or alternative groups following disengagement.

Measurable Benchmarks: The effectiveness of this linkage process can be reflected in two types of benchmarks. The first involves individual or collective process measures such as percentage of clients involved in recovery support meetings during the first 30 days following their discharge from treatment, the total and average number of weekly meetings attended in the first 90 days following discharge from treatment or the percentage of individuals referred to Twelve Step groups who have a temporary or permanent sponsor within 30 days of discharge. The second type of measurable benchmark involves collective changes in clinical/recovery outcomes that follow development of assertive linkage processes. Such hoped for outcome measures would include decreases in post-treatment relapse rates, extended lengths of time from discharge to first use, shorter episodes of lapse/relapse, reductions in treatment readmissions, lower post-treatment mortality rates and increases in quality of recovery measures.

Working with Mutual Aid Service Structures: Most recovery mutual aid groups have established service structures and procedures that guide the relationship between

each group and treatment organization. The most formal of these guidelines are the Hospital and Institutions (H&I) Committees (also referred to as Treatment Facility [T.F.] Committees) developed within A.A. and replicated with minor adaptations in N.A., C.A. and other Twelve Step groups. A good orientation to H&I Committees and the relationship between Twelve Step programs and treatment organizations can be obtained by reviewing the following documents:

- *A.A. Guidelines: Treatment Facility Committees* http://www.alcoholics-anonymous.org/default/en_pdfs/mg-14_treatfacilcomm.pdf.
- *How A.A. Members Cooperate with other Community Efforts to Help Alcoholics* (A.A. Pamphlet)
- *A.A. and Treatment Facilities* (A.A. Pamphlet)
- *A.A. in Hospitals* (A.A. Pamphlet)
- *Basic H & I Guide of Narcotics Anonymous* http://www.na.org/h-i/hi-guidetoc05.htm
- *Narcotics Anonymous: In Cooperation with Therapeutic Communities Worldwide* (http://www.na.org/prespapers/in-cooperation.htm)

Some readers may respond that they have attempted to work with such committees but found them populated with "fundamentalists" who were not open to new ways of engaging and retaining individuals who have struggled to achieve stable recovery. Relationships with service committees are best approached as a long-term endeavor requiring tolerance, mutual respect and a process of mutual learning.

The service structure of recovery programs not based on the Twelve Steps can be found on the Internet websites of these organizations or by contacting them directly. Links to these sites and organizations can be found at http://facesandvoicesofrecovery.org/resources/support_home.php.

We would offer the following suggestions to build or renew the relationship between local treatment organizations and local recovery support groups:

- Respect the guidelines that each group has established for members who work or serve as volunteers in the addictions field (See *A.A. Guidelines for A.A. Members Employed in the Alcoholism Field.* (ND). New York: General Service Office, Alcoholics Anonymous.)
- Where possible, develop a single point of contact with each group (e.g., the chairperson of the H&I Committee).
- Establish at least annual meetings between your agency and the service committees of local recovery support groups to review such issues as support meetings hosted at the treatment facility, transportation assistance to outside meetings, access to literature for clients, procedures for temporary sponsorship, use of speakers to make presentations about the group to clients, and any problems that have arisen in the relationship between the treatment facility, its clients, and the group.
- To help personalize the linkage process (in consultation with the service committee or representative), develop a cadre of reliable individuals with diverse characteristics and temperaments that will serve as temporary guides in getting a new person welcomed into the group.

- Avoid linkage practices that potentially violate the culture of the local group (e.g., bussing 30 new people in treatment to a small community meeting or linking heroin addicts without a history of alcohol use/problems to A.A. with narrow interpretations of A.A.'s tradition governing membership.)

In a process aimed at reconnecting treatment, recovery and community, treatment leaders are again beginning to define themselves as a part of the growing recovery community and see themselves as personally and institutionally accountable to this recovery community. Leaders and staff of progressive treatment organizations are again participating in communal meetings of local communities of recovery and opening the doors of their facilities to local recovery communities as a venue for social support and service. Leaders within American communities of recovery are also beginning to articulate the need for these communities to more effectively reach out to treatment organizations and the individuals and families they serve.

<u>Encouraging Staff Exposure and Participation in Local Recovery Support Groups and Internet-based Recovery Resources:</u> Assertive linkage to recovery support groups and the larger network of recovery community resources requires an in-depth knowledge of these local groups and resources. In the 1960s and 1970s, participation in local (open) meetings was expected of all staff, a practice that created an in-depth knowledge of different recovery support structures and something of the personality of each particular meeting. The shift from acute models of care to recovery management will stir calls for a renewal of this knowledge base. Programs can enhance this knowledge by encouraging service staff and volunteers to:

- Read the literature of the spectrum of recovery support groups,
- Visit open meetings of local recovery support groups,
- Visit Internet sites of the major recovery support groups and become familiar with various on-line recovery support meetings,
- Invite representatives of various recovery support groups to provide in-service training for clinical and support staff, and
- Participate in local recovery celebration activities either as a person in recovery or a friend of recovery.

<u>Developing Recovery Volunteer Programs:</u> One of the most vibrant recovery volunteer programs developed by an addiction treatment program was that developed at Lutheran General Hospital in the early 1970s. The hospital's alcoholism treatment unit recruited more than 200 volunteer A.A. and Al-Anon members who collectively provided more than 10,000 hours of volunteer service each year. The volunteers provided around the clock social support to the individuals and families going through treatment and helped link them to outside support meetings in the community (McInerney, 1970). Such dynamic volunteer programs dissipated amidst the growing professionalization of the field in the 1980s and 1990s, but efforts to restore them are increasing as part of the larger shift from acute models of treatment to models of sustained recovery management. Portrayed below are some of the functions that recovery volunteers can provide within the treatment milieu.[3]

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[3] Those interested in developing or enhancing a recovery volunteer program will find the following resource helpful: *Successful Strategies for Recruiting, Training, and Utilizing*

Representative Functions of Recovery Community Volunteers
1. Offering themselves as "living proof" of the reality of recovery and the transformative power of recovery.   2. Sharing their recovery status and, when well-timed and appropriate, their recovery story.   3. Serving as a recovery lifestyle consultant, sharing practical tips on living as a person in recovery within one's family, school or workplace and larger community.   4. Helping staff and paid peer-support specialists guide the client/family into relationships with one or more local or virtual communities of recovery.   5. Providing support (e.g., information, transportation) and advocacy to each client/family to facilitate access to needed recovery services.   6. Providing face-to-face, telephone and email communications for purposes of monitoring, recovery coaching, and, when needed, early re-intervention.   7. Training family members (or persons in recovery) to run family education seminars and family support groups.

Developing or Renewing Recovery (Alumni) Associations: One of the dynamic bridges between treatment and the larger recovery community is provided through Recovery (Alumni) Associations that provide recovery support services in their own right to clients during and following treatment and who constitute an important pool from which volunteers can be drawn.

Profile of a Vibrant & Enduring Recovery Alumni Association
Group: Discovery (Alumni Association of New Day Center at Hinsdale Hospital, Hinsdale, IL)   Founded: Early 1980s   Founded by: John Daniels (aftercare director) and two graduates and their spouses.   Membership Size: Ranged between 250-500 over past ten years   Duration of Participation: 30-40% have participated for more than 5 years with some of founding members still participating   Meeting Frequency: Monthly social events and 2-3 organizational meetings each year   Social Event Activities: Potlucks, dinners out, bowling, weekend trips   Average Event Attendance: 60-70   Distinctiveness / Keys to Success: Involvement of partners/spouses and children; development of long-term relationships with individuals/families in recovery; autonomy of group from treatment organization (New Day only provides space and assistance with mailings)

Membership Fee: $5 per person per year
Association Assets: Approximately $10,000 used to support activities and participation of any members who cannot afford activities.
Greatest Challenge to Date: Engaging and retaining adolescents after treatment.

Source: Interview with Don Malec, Discovery Leader, January 19, 2006.

Recovery alumni associations can exist as a permanent recovery support structure or as a transitory support structure with its need diminishing as those completing primary treatment become more involved within and interact within local communities of recovery (Schwartz, personal communication, 2006). It is our experience that programs who most effectively link individuals to natural communities of recovery diminish the need for the treatment center alumni association as a support structure.

Developing Formal Peer-based Recovery Support Programs: There are a growing number of treatment and recovery support organizations experimenting with Peer-based recovery support services (P-BRSS) via new service roles (recovery coaches, peer assistants, recovery mentors, recovery support specialists). P-BRSS are non-clinical services offered on a paid or volunteer basis that guide individuals and families into a recovery-based lifestyle following severe alcohol and other drug problems. P-BRSS offer normative guidance on the recovery experience (stage-appropriate recovery education), linkage to communities of recovery, consultation on problems encountered in early recovery, on-going monitoring of recovery stability, assistance with lifestyle reconstruction (e.g., sober housing, sober leisure, etc.), and, when needed, a point of early re-intervention into lapses or relapses. P-BRSS are reflected in new roles going by such titles as recovery coaches, peer recovery mentors, recovery support specialists and recovery assistants. Peer-based recovery support services are being implemented under a variety of rationales (White, 2004).

1. Helpers derive significant therapeutic benefit from the process of assisting others (the "helper principle")(Riessman, 1965, 1990).
2. People who have overcome adversity can develop special sensitivities and skills in helping others experiencing the same adversity-a "wounded healer" tradition that has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements.
3. The inadequacy of acute care models of treatment for people with high problem severity and complexity and low recovery capital is evident in low engagement rates, high attrition rates during treatment, low continuing care participation, and high re-admission rates.
4. Many addicted people benefit from a personal "guide" who facilitates disengagement from the culture of addiction and engagement in a culture of recovery.
5. Peer-based recovery support relationships that are natural, reciprocal, and enduring are not mutually exclusive of, but qualitatively superior to, relationships that are hierarchical, commercialized and transient.

6. P-BRSS are an attempt to re-link treatment and recovery, move the locus of treatment from the treatment institution into the natural environment of those seeking treatment services, and facilitate the shift from toxic drug dependencies to "prodependence on peers" (Nealon-Woods, et al, 1995).

P-BRSS are being piloted in some of the White House-initiated Access to Recovery Programs, within the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP), and within a growing number of programs experimenting with models of recovery management. The states of Connecticut, Arizona and Vermont have taken the lead in encouraging the development of recovery coach roles in treatment and recovery advocacy and support organizations, and there is a recent trend toward the privatization of recovery support services (e.g., Hired Power www.hiredpower.com).

Seen as a whole, the recovery coach role is comprised of multiple roles. The recovery coach is a:

- motivator and cheerleader (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement),
- ally and confidant (genuinely cares, listens, and can be trusted with confidences)
- truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting),
- role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice),
- problem solver (identifies and helps resolve personal and environmental obstacles to recovery),
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support),
- advocate (helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights),
- community organizer (helps develop and expand available recovery support resources),
- lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living), and
- a friend (provides companionship)(White, 2004).

It is also important to note what the recovery coach role is not. First, the recovery coach is not a therapist or counselor, although certain qualities and functions overlap with this role. This fact is reflected in the retraining that must occur when persons in recovery who are certified addiction counselors, psychologists and social workers volunteer to serve as addiction counselors. Such individuals must be retrained to eschew professional jargon and counseling techniques for a true peer support role (Ben Bass, personal communication). The recovery coach also is not a Twelve-Step sponsor and must not duplicate support activities that are being or could be provided by the larger recovery community.[4]

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[4] See Loveland and Boyle (2005) for a recovery coach implementation manual.

There are many models of organizing P-BRSS. One model gaining increasing attention is that of the Recovery Community Center (RCC) developed by the Connecticut Community of Addiction Recovery (CCAR), which describes its RCC as follows:

> *A Recovery Community Center (RCC) is a recovery-oriented sanctuary anchored in the heart of the community. It exists 1) to put a face on addiction recovery, 2) to build "recovery capital" in individuals, families and communities and 3) to serve as a physical location where CCAR can organize the local recovery community's ability to care.* (From Core Elements of A Recovery Community Center, CCAR, 2006)

At CCAR, the RCC moves recovery from "the church basements to main street," provides a venue for sober socializing, a physical place for recovery development (linkage to recovery-conducive employment, recovery homes, recovery workshops, planned leisure activities, community service work) and as a medium for connecting people with recovery needs to people with recovery assets. CCAR sees its RCC as an organizational/human bridge between the professional treatment community and the recovery community. Where addiction counselors and Twelve Step sponsors view their service focus in terms of individuals/families that have sought their help, the RCC defines its "client" as the community—the WHOLE community. It is an innovative framework through which peer-based recovery support services can be delivered.

2006 Profile of the Vermont Recovery Center Network
Number of Recovery Centers (RC): 6
Usual Hours of Operation: 8 am to 10 pm
Average hours per week of Operation: 69
Number of Full- and Part-time Paid staff: 9
Primary Financial Support: Yearly grant from Vermont Department of Health / Division of Alcohol and Drug Abuse Programs
Secondary Financial Support: Local grants, local fundraising, membership fees
Number of Volunteers Per Center: Ranges from 7-50; average of 27 per center
Average Weekly Volunteer Hours per Center: Ranges from 20-225; averages 93 volunteer hours per week/per center
Number of Weekly Recovery Meetings: Range from 4-20; total of 66 recovery meetings per week at the 6 centers
Total Number of Participant Visits Past Quarter: 20,741
Average Age of Participants: 41
Average Length To Date of RC Participation: 1.75 years
% of Participant Evaluations Noting Role of RC in Finding Recovery: 55%
% of Participant Evaluations Noting Role of RC in Maintaining Recovery: 94%
% of Participants Who Have Participated in Treatment Programs in their Lifetime: 73%
% of Participants Who Have Participated in Treatment Programs in Past Year: 24%
Core RC Activities: Social support and fellowship, recovery meetings, recovery education (e.g., life skills training), linkage to specific services (e.g., treatment, housing, family services, employment, etc.), and social activities.
Future Vision: 12 recovery centers geographically dispersed across the state, enhanced linkage between professional treatment and local recovery support centers, and increased

community awareness of recovery by making recovery visible on "main street."

Source: Personal Communication, Patty McCarthy, Executive Director, Friends of Recovery Vermont; Data from Vermont Department of Health / Division of Alcohol and Drug Abuse Programs

Peer-based recovery support services are not without potential pitfalls, including: the vulnerability of peer service providers and recipients; problems of role delineation among coach, counselor and sponsor; the lack of models for recruitment, orientation/training, and on-going supervision of P-BRSS specialists; and the lack of a code of ethics to guide the delivery of peer-based services (e.g., guidelines on such issues as self-disclosure, boundaries of competence, dual relationships, gifts, and level of accessibility, to name just a few).

The Process of Linking Clients/Families to Recovery Support Groups and Communities of Recovery

Traditional "Aftercare" versus Assertive Approaches to Continuing Care (AACC): Revamping the process of linking clients to communities of recovery is part of the larger revamping of the traditional idea of "aftercare." In the traditional view, acute treatment initiates and stabilizes recovery and provides aftercare in the form of step-down treatment (outpatient sessions following discharge from residential). Participation in professionally directed "aftercare groups" and participation in A.A. or other recovery support groups would serve to maintain recovery. In this model, aftercare arrangements rely primarily upon verbal encouragement for such participation to each client by his or her counselor and are only available to those clients who have completed recommended levels of care.

In the new recovery management model, all care is part of a process of assertive continuing care. In contrast to traditional aftercare models, assertive approaches to continuing care:

- encompass all admitted clients/families, not just those who successfully "graduate," including those who terminated treatment against staff advice or were administratively ("therapeutically") discharged,
- place primary responsibility for post-treatment contact in AACC with the treatment institution, not the client,
- involve both scheduled and unscheduled contact (e.g., "I've been thinking about you today and thought I would call to say hi and see how things were going."),
- capitalize on temporal windows of vulnerability (saturation of check-ups and support in the first 90 days following treatment) and increase monitoring and support during periods of identified vulnerability,
- individualize (increases and decreases) the duration and intensity of check-ups and support based on each client's degree of problem severity, the depth of his or her recovery capital and the ongoing stability or instability of his or her recovery program,

- utilize assertive (see discussion below) linkage rather than passive referral to communities of recovery,[5]
- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support and mailed and emailed communications,
- place emphasis on those combinations and sequences of services/experiences that can facilitate the movement from recovery initiation to stable recovery maintenance,
- emphasize support contacts with clients in their natural environments,
- may be delivered either by counselors, recovery coaches or trained volunteer recovery support specialists, and
- emphasize continuity of contact and service (rapport building and rapport maintenance) in a primary recovery support relationship over time (Dr. Mark Godley, Director of Research, Chestnut Health Systems, personal communication, February, 2006).

Building a Long-term Recovery Support Relationship: Clients receive mixed messages from those of us in the addiction treatment field. We TELL them that addiction is a chronic disorder and then treat them in ever-briefer episodes of treatment. We TELL them that recovery is a prolonged process rather than an event, but then we "discharge"/"graduate" and abandon them to pursue this process on their own. We TALK about the importance of post-treatment recovery support through peer-based recovery support groups, but we do not monitor the strength and durability of such connections. We TELL clients if they get in trouble after treatment to get back to us for additional help, but we all too often shame the returning client to the point that many stop seeking treatment or keep seeking help at new treatment centers. If we as addiction professionals really believe that addiction is a chronic disorder, then it is time our professional behavior matched our professional rhetoric.

Linking clients to recovery support groups and broader communities of recovery is best achieved within a long-term recovery support relationship, whether the person who initiates that relationship is a counselor or a paid or volunteer recovery coach. As noted earlier, addictions researchers are investigating the power of post-treatment check-ups and support via face-to-face-interviews, mail and telephone contact and Internet-based monitoring and support. New research technologies, generating 90+% follow-up rates in longitudinal studies of addiction treatment, could be clinically adapted for use as ongoing recovery support interventions (Scott & Dennis, 2000). Such technologies create positive space in peoples' lives to forge long-term relationships that have meaning and value. Treatment centers such as the Betty Ford Center and Hazelden are trying to extend their support services beyond primary treatment through the use of telephone-based check-ups over the months following treatment.

Competing with the Culture of Addiction: Many clients with severe AOD problems are deeply enmeshed in cultures of addiction—an entrenched pattern of daily rituals and social relationships that sustain addiction. The fragileness of post-treatment adjustment is in part due to the resurging siren call of these rituals and relationships. To put it bluntly, representatives from the culture of addiction conduct aggressive post-

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[5] Referral is not linkage; it is affirmation of the need for linkage and the hope that linkage will happen. Linkage is a process that assures that the connection between an individual and indigenous recovery support systems really happens.

treatment monitoring and re-intervention with individuals who have completed treatment, but we do not. What is wrong with this picture? If we are truly committed to helping our clients achieve long-term recovery and recognize that they are precariously balanced between recovery and re-addiction in the days, weeks, months and early years following treatment, then we must be in their lives as a positive influence on these daily recovery or re-addiction decisions that are made and help replace this culture of addiction with a culture of recovery (White, 1996).

Linkage Steps: Encouragement procedures can increase recovery support group affiliation and participation. Such procedures include:

- educating clients about the importance and potential benefits of post-treatment recovery support services ("Just as clients often minimize the severity of their AOD problems, they also tend to underestimate what will be required to successfully resolve those problems."),
- soliciting the client's past experience with solo experiments in sobriety
- soliciting client's past experience with and perceptions (stereotypes) of recovery mutual aid groups,
- reviewing the menu of post-treatment recovery support options (family, social, occupational, formal support groups),
- identifying important meeting characteristics (e.g., religious, spiritual, secular; smoking or nonsmoking; gender; ethnicity; age; geographical access) (Forman, 2002),
- using assertive rather than passive linkage procedures, e.g., orienting client about what to expect in his or her first meeting (As an example, see http://www.aa.org/default/en_about_aa.cfm?pageid=25, http://www.bma-wellness.com/papers/First_AA_Meeting.html and http://www.bma-wellness.com/papers/First_AA_Meeting.html#Locating%20a%20meeting) as a guide for what the client can expect at his or her first A.A. meeting),
- linking each client to a particular person (from a list of volunteer guides) to orient and guide the client into relationship with a local group and linking each client to a specific meeting for their initial exposure,
- demonstrating personal enthusiasm and optimism to the client about recovery support group participation,
- resolving obstacles to participation, e.g., day care, transportation,
- clarifying the role differences between the counselor, the recovery coach and the sponsor to avoid confusion, conflicting loyalties and manipulative splitting by the client,
- monitoring and evaluating each client's initial and ongoing responses to that person/meeting via follow-up phone calls, emails, or visits,
- providing support for continued contact or exploring alternatives in response to mismatches between person and group, and
- linking (where possible) family members to support structures congruent with the recovery framework of the client, e.g., referring spouses and children to Al-Anon and Alateen when the client is participating in A.A.[6]

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[6] For evidence of the effectiveness of encouragement procedures, see Mallams, et al, 1982.

In most cases, the addiction counselor will have explored the potential value of recovery support group participation by the end of primary treatment. When this is not the case, then the counselor or recovery coach responsible for post-treatment check-ups must begin this process anew. Reinforcing the importance of recovery support group participation can begin with helping the client re-assess his or her past efforts at solo problem resolution.

Past Problem Resolution Efforts (Key Interview Questions)

1. How many times have you attempted on your own to cut down your alcohol or other drug use?
2. What is the longest time you were able to sustain your goal of cutting down?
3. How many times have you attempted on your own to stop your alcohol and other drug use?
4. What is the longest time you were able to sustain your goal of not drinking or using drugs?
5. Is there an average time that your efforts to cut down or stop use started to fail for you?
6. In your best past prior efforts to cut down or stop your drinking and/or drug use, what were you doing that helped make this effort more successful?
7. Which do you think is most achievable for you in the future: cutting down your alcohol and/or drug use or stopping all non-medical use of alcohol and drugs?
8. If you use your past experience as a guide, what can you do in the next year to make your current efforts more successful?
9. How will you know if what you are trying now is working for you?
10. What are the earliest signs that would tell you that the strategy you are using this time is not working?

Some clients will sustain their recovery just fine without recovery support group participation, while others will come to see such participation as helpful or essential. The goal is not to get all clients to like going to recovery support meetings, although some will develop that sentiment. The goal is to draw from the client's own experience why he or she needs to participate in such groups and to use their experience to determine what type of group best meets that need. There is something almost mystical in the chemistry between the individual and a recovery support group/community.

When we speak of "recovery community," these qualities take on added significance because of the shared wounds its members bring to their membership in this community. It is here that those who have never experienced sanctuary often discover a place where they feel physically and psychologically safe for the first time. Here one is accepted not in spite of ones imperfectness but because of the very nature of that imperfectness. It is this shared "torn-to-pieces-hood" (as William James called it) that turns "people who normally would not mix" into a

"fellowship." It is here that, in discovering one's self in the stories of others, people discover themselves and a "narrative community" whose members not only exchange their stories but possess a "shared story." Within such a community, one can find a deep sense of fit-a sense of finally discovering and connecting to the whole of which one is a part. The recovery community is a place where shared pain and hope can be woven by its members into life-saving stories whose mutual exchange is more akin to communion than communication. This sanctuary of the estranged fills spiritual as well as physical space. It is a place of refuge, refreshment and renewal. It is a place that defies commercialization-a place whose most important assets are not for sale. There is in this dynamic interaction [of person and group] as much a sense of having been chosen as there is a sense of choosing a particular framework of recovery. It is both a "you belong with us" connection between the group and the individual and a "this is where I belong" connection between the individual and the group. (White, 2001a)

That type of connection can be enhanced by reviewing each client's history of exposure to recovery support groups[7], his or her attitudes toward such groups, the factors most important to a positive group experience and his or her plans for immediate participation in such groups.

Which of the following are important for you in selecting a recovery support group? (Check all that apply) People who:
___ have experience with my primary drug
___ are the same gender
___ are close to my age
___ share my ethnic/cultural background
___ share my views on religion, spirituality or secularity
___ share my sexual orientation
___ smoke tobacco
___ do not smoke tobacco
___ have tolerant attitudes toward mental illness
___ have tolerant attitudes toward medications prescribed for addiction or mental illness
___ have prior experience in the criminal justice system
___ do not have prior experience in the criminal justice system
___ have approximately the same income level
___ have had very severe alcohol/drug problems
___ have had mild to moderate alcohol/drug problems
___ share my goal of complete abstinence
___ share my goal of moderated use

Once a plan has been formulated, the addiction counselor or recovery coach can begin the process of assertively linking the client to a recovery support group and its

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[7] For a more detailed format for reviewing past support group experience, see Nicolaus, M. (2003). *Recovery by Choice*. Oakland, CA: LifeRing Press, pp. 235-241.

larger community of recovery. There are two phases in this linkage process. The first phase, opening the referral, begins in the planning process and proceeds through two additional steps: 1) when necessary, orienting the client to the particular recovery support society he or she has chosen to explore and 2) providing a direct, human connection between the client and either a representative of a recovery support organization or his or her first exposure to meetings of that society. The second step can be achieved by facilitating a visit between the client and a recovery group representative or the recovery coach taking the client to his or her first meeting. Where a guide is used, an important point is that the connection between the client and the recovery group is not complete until the guide steps out of the middle of that formative relationship.

The second phase is closing the referral linkage. Where the first stage guided the client into relationship with a community of recovered and recovering people, the second stage is designed to ensure individual-group fit by assessing strength and durability of relationship between the client and the group. Such assessment can be incorporated into routine post-treatment check-ups.

When Few Recovery Support Resources are Available: In communities with few recovery support resources it may be necessary for the addictions counselor or recovery coach to devote time to developing a broader pool of recovery support resources in the community. As an example, addictions counselors working in adolescent treatment programs often send adolescents back to local community and school environments with no indigenous recovery support services. The inevitable result is a high relapse rate—events that often occur within hours or days following discharge from treatment. An alternative approach is to supplement clinical services to the adolescent and family with time in the adolescent's community organizing school-based recovery support services and youth-oriented recovery groups and recovery activities.

In communities where few specialized recovery support resources exist and clients are not affiliated with mainstream recovery groups, special supports may be organized that can evolve into more permanent recovery support structures. This strategy can exert an important role in the growth, diversity and vitality of the local recovery community.

Steps in Developing Special Recovery Support Groups
• Identify an area of unmet need for recovery support, e.g., the absence of women's meetings, young people's meetings, absence of secular recovery groups, etc.
• Sponsor an open-attend (attend as long as you like) continuing care group as an adjunct or alternative (for some).
• Continue the group until a strong core group of members coalesces.
• Recruit the strongest group members as peer-leaders, encourage and cultivate their leadership, decrease your role but not your presence as their leadership activities increase.
• Arrange for your peer-leaders to facilitate the group sometimes in your absence and process with the leaders and group members how this went in your absence.
• Raise the possibility of shifting the group from a professionally-directed continuing care group to a peer-sponsored and peer-led

recovery support group.
- Provide info to assist group if they want to shift the group to a registered A.A., N.A., or other established recovery group.
- Monitor the status of the group and provide support to peer leaders.

NOTE: On-going cycles of this process may be required when established leaders relocate or mature out (in the case of young people's meetings).

Steps to Expand the Variety of Recovery Support Groups: Some communities lack Twelve Step recovery groups or alternatives to Twelve Step groups. Counselors and addiction counselors can also play important roles in enhancing the varieties of recovery support structures within their local communities.

Seeding Diversity in Local Recovery Support Groups
1. Remain personally knowledgeable and up to date on established and new recovery support groups.
2. Maintain a library of recovery support group literature and contact information that can be shared with your clients.
3. Encourage clients with computer resources and capabilities to explore the websites of various recovery support groups and to explore the world of Internet recovery support meetings. (Be prepared to provide cards with website listings.)
4. Invite guest speakers representing various recovery groups to visit your community and make presentations to clients and other interested parties.
5. Encourage individuals who are not responding to existing support structures to consider starting their own recovery support group.
6. Make clients aware of the growing movement to create broader recovery support structures, e.g., recovery homes, recovery schools, recovery work co-ops, etc.
7. Serve as a consultant to recovering individuals/families who want to explore development of a special recovery support group.

Providing Long-term Recovery Management

Linking clients from addiction treatment to communities of recovery has the greatest impact when this activity is imbedded within a large framework of long-term recovery management and support that encompasses pre-treatment engagement and recovery priming (motivational enhancement), in-treatment recovery support services (to enhance engagement, strengthen recovery initiation, and reduce treatment attrition) and post-treatment recovery support services. Our focus will be on the latter of these service categories.

Post-treatment recovery management begins at the point of discharge from primary treatment. In the emerging recovery management model, this period is considered the key to fully transferring what the client learned in treatment to his or her natural life in the community. The steps in this process include 1) ongoing check-ups and

support, 2) stage appropriate recovery education (recovery coaching), 3) validating or reinitiating assertive linkage to recovery support groups and the larger network of community recovery activities, 4) resolving personal and environmental obstacles to recovery, and, 5) when needed, early re-intervention and re-linkage to recovery support group resources or professional treatment. The following discussion focuses primarily upon the check-up and linking functions.

Monitoring involves mutually agreed upon contact between the client and a recovery coach so that both may assess the client's status and explore the recovery process. The monitoring process usually begins with a higher frequency of contact in the first 90 days following treatment and decreases in frequency and intensity after that, with the proviso that check-up frequency can increase by mutual agreement at any time the client enters a period of heightened vulnerability. In most cases, clients with lower problem severity and higher recovery capital require shorter and lower intensity monitoring than do those with higher problem severity and lower recovery capital.

The major factor that compromises recovery from chronic health care problems is failure of the individual to adhere to recovery maintenance protocol, e.g., following medication directions, diet restrictions, exercise recommendations and other self-care prescriptions (McLellan, et al, 2000). Sustained monitoring is a powerful tool to enhance adherence to recovery maintenance protocol, a fact revealed in the addictions field from the discovery that research follow-up contacts actually generate their own therapeutic effects (Sobell and Sobell, 1981).

The following table illustrates the range of interventions that are indicated across five different circumstances the client may be in at the time of follow-up contact.

Status at Follow-up	Intervention Options
No Problems Reported	-Expressions of regard & concern -Identify sources (decisions, actions, people) of successful recovery maintenance -Identify positive consequences of recovery -Praise success -Maintain routine check-up schedule
Instability/distress, no alcohol/drug use but high risk of relapse (e.g. cravings, thoughts of using)	-Expressions of regard & concern -Elicit positive effects of sobriety & potential negative consequences of returning to AOD use -Intensify peer recovery supports -Enlist support from significant other -Explore option of contact with professional helper -Linkage to sober living environment -Increase check-up contact in next 30 days
Slip with return to abstinence	-Expressions of regard & concern -Evaluation of the slip (& lessons learned) -Evaluation of the strength of peer recovery supports (Re-linkage or linkage to alternative group) -Elicit positive effects of sobriety & potential negative consequences of sustained return to AOD

	use
	-Elicit recommitment to recovery
	-Increase frequency of check-ups for next 60 days to verify recovery stability
Alcohol/drug use without reported negative consequences	--Expressions of regard & concern
	-Review of past consequences of AOD use
	-Evaluate abstinence goal & client's commitment to continue AOD use or return to sobriety goal
	-Elicit positive effects of sobriety & potential negative consequences of sustained return to AOD use
	-Explore earliest ways client would know that AOD use was becoming a problem again
	-Enlist significant other in monitoring and support
	-Option of re-linkage to peer and professional support
	-Apply test of moderation ground rules, e.g., Miller & Munoz, 2005
	-Increase check-ups for next 90 days
Alcohol/drug use with negative consequences	-Expressions of regard and concern
	-Elicit duration & intensity of negative consequences and future problems if use continues
	-Elicit how these problems would change if sobriety re-initiated
	-Assertive linkage to peer recovery supports
	-Assertive linkage to professional supports
	-Support to family/significant other
	-Increase monitoring of response to peer & professional supports

Source: Adapted and amplified from Stout, et al, 1999.

A Brief Note on Early Re-intervention: In the routine process of post treatment monitoring and assessing individual responses to post-treatment mutual aid involvement, counselors and recovery coaches will experience encounters in which the client is on the brink of lapse/relapse or has already experienced lapse/relapse. We would offer several points to consider regarding the process of early re-intervention. *First*, re-intervention is important because it provides a point of recovery restabilization when problem severity has not fully re-escalated and when the client still has recovery assets that can facilitate long-term recovery (assets that are depleted over time with re-addiction). The goals of re-intervention are to reduce the client's immediate threat of injury to self and others, shorten the length and intensity of the lapse/relapse experience and use the lapse/relapse experience to elevate the commitment to recovery and strengthen relationships with the community of recovery.

Second, many clients experience intense shame following relapse and that shame is a major barrier to recovery restabilization. That shame can be diminished by providing

normative data on relapse and recovery, praising the continued commitment to recovery, and re-affirming the recovery support partnership. *Third*, not everyone who lapses or relapses needs readmission to primary treatment. Those who do need treatment may not need the same level of care they most recently experienced. The problem may lie, not in the mechanics of recovery initiation, but in the transition from recovery initiation to recovery maintenance in the client's natural environment. The focus should be on building recovery supports into this environment to facilitate the development of a sobriety-based lifestyle and skills in the sobriety-based resolution of problems in daily living. Thus, a call to a sponsor and re-linkage to a support group may be more appropriate than readmission to treatment for some clients. Where treatment is needed, that linkage process must be direct rather than simply verbal encouragement. *Finally*, while post-treatment re-intervention is part of the process of sustained recovery management, the clinical strategies contain many of the elements essential to effective brief interventions: empathy, feedback, emphasis on personal responsibility, clarification of choices, professional advice, and expressions of confidence in client's ability to change (Miller and Rollnick, 1991).

Styles of Long-term Recovery Mutual Aid Affiliation: It is important to understand the varieties and styles of recovery maintenance and the evolution of these styles over time. For example, everyone who stops regularly attending recovery support meetings is not on the verge of relapse and re-addiction. A recent study of patterns of A.A. attendance concluded that, "contrary to A.A. lore, many who connect only for a while do well afterwards" (Kaskutas, et al, 2005). This does not diminish the importance of A.A.; in fact, it suggests measuring the impact of A.A. and other recovery support groups solely by current membership statistics results in a gross underestimate of the total contributions such groups make to addiction recovery. While some people will need or profit from lifelong attendance at A.A. meetings, others will disengage from or decrease meeting participation while sustaining stable recovery. Research on what distinguishes the "maintainers" from the "disengagers" is limited; we suspect that cumulative studies will reveal that the former are made up of those with addictions of greater severity and complexity and fewer recovery supports, as well as people who shift the primary focus of their recovery group participation to social fellowship and spiritual development. Recovery stability and vulnerability for relapse must be measured by looking at the whole person and their recovery environment, rather than solely on meeting attendance or non-attendance.

Summary

In this essay, we have tried to:

1) describe the emergence of a recovery paradigm as a new organizing concept for treatment and recovery support services,

2) summarize the scientific evidence supporting post-treatment check-ups and assertive linkage to peer-based recovery support groups,

3) describe the growing diversity of American communities of recovery,

4) outline strategies for building/strengthening relationships between treatment organizations and local recovery societies, and

5)   offer suggestions on how, within a larger framework of post-treatment monitoring and support, addiction counselors and recovery coaches can link individuals/families to recovery support groups.

It is our hope that this effort adds momentum to the movement to shift addiction treatment from an acute care model to a model of sustained recovery management.

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Appendix A

Resources to Contact about How to Organize a Recovery Community Center

Asian Pacific American Community Recovery Network (ACORN)
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720 8th Avenue South, Suite 200
Seattle, WA 98104
(206) 695-7649
kellyt@acrs.org

Connecticut Community for Addiction Recovery (CCAR)
Phillip A. Valentine, Executive Director
530 Silas Deane Highway Suite 220
Wethersfield, CT 06109
(860) 571-2985
phillip@ccar.us
http://ccar.us/

Detroit Recovery Project (DRP)
Andre Johnson, Program Manager
1151 Taylor Street, Room 417C
Detroit, MI 48202
(313) 876-0770

Easy Does It, Inc.
Dave Reyher, Executive Director
1300 Hilltop Road
Leesport, PA 19533
(610) 373-2463
dreyheredi@comcast.net

El Paso Alliance
Ben Bass, Executive Director
6000 Welch No. 7
El Paso, TX 79905
Phone: 915-594-7000
http://www.recoveryalliance.net/
BBass@RecoveryAlliance.net

Friends of Recovery – Vermont (FOR-VT)
Patty McCarthy, Executive Director
PO Box 1202
Montpelier, VT 05601
(802) 229-6103, 1 (800) 769-2798
RecoveryVT@aol.com http://www.friendsofrecoveryvt.org/

Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT)
Bev Haberle, Project Director
Women's Community Recovery Center
Bailiwick Office Complex Suite 12/14
Doylestown, PA 18901
(215) 345-6644 Bhaberle@bccadd.org

Recovery Association Project (RAP)
Kathy Brazell, Executive Director
1100 NE 28th Avenue, Portland, OR 97232
Phone 503.493.9211 Fax 503.493.9249
www.rap-nw.org
kb@rap-nw.org

RECOVER Project
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55 Federal Street, Suite 125
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