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Addiction Technology Transfer Center Network
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Peer-based Addiction Recovery Support

History, Theory, Practice, and Scientific Evaluation

William L. White, MA

Great Lakes Addiction Technology Transfer Center

**Philadelphia Department of Behavioral Health
and Mental Retardation Services**

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Dedication

This monograph is dedicated to:

Barbara Weiner and Rebecca Rowe of Hazelden Library, and to Stephanie Merkle and Christopher Roberts, research assistants at Chestnut Health Systems. This monograph was possible only through their tenacious efforts to procure hundreds of historical documents, scientific studies, trade journal articles, posted papers, conference presentations, and other unpublished manuscripts. Barbara, Rebecca, Stephanie and Christopher, and their counterparts around the country receive far less acknowledgment for their contributions to the field than they deserve.

Thomasina Borkman, for her pioneering work on experiential learning and peer-based recovery support organizations.

Those working on the front lines of peer-based addiction recovery support services. Thank you for opening your lives and your organizations to me.



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Welcome

**Lonnetta Albright, Executive Director
Great Lakes Addiction Technology Transfer Center**

**Michael T. Flaherty, PhD, Principal Investigator
Northeast Addiction Technology Transfer Center**

We welcome you to this, the sixth effort in our monograph series designed to explore in depth the theoretical and practical aspects of peer-based addiction recovery support services and recovery-oriented systems of care. Once again, we have had the benefit of William L. White's expertise and passion in the conception and execution of this document.

After all the dedication, skill, and care that addiction professionals devote to our clients' well being, we all too often see our best work erode as fragile people return to the same circumstances and environments that fostered their illness. The peer-based recovery support model has arisen to nourish and protect the recovery that in many cases starts in professional treatment, and from the beginning William L. White has been one of its strongest champions.

As someone who has spent most of his career working toward the professionalization of the addiction treatment field—drawing the best from us and advocating the best *for* us—Mr. White is in a unique position to explore the value of services that extend beyond professional treatment. In his travels and studies, he has absorbed an encyclopedic knowledge of recovery systems and services, from potential to pitfalls.

In earlier documents, Mr. White and colleagues have explored the need to understand addiction's potential as a chronic illness requiring continuing care, the implications of recovery management for treatment systems and for the field as a whole, the critical role of professional treatment in initiating recovery, and the science—existing and recommended—that we need for better understanding and support of recovery. In this volume, he turns his attention to the peers who provide ongoing recovery support services before, around, and beyond professional treatment. To dispel the myths that say this model has not been tested or evaluated and is not supported by scientific evidence or the literature of our profession, the monograph provides 19 program profiles and includes more than 850 scientific and professional references.

As an added benefit of this exploration, Mr. White presents and clarifies two very distinct but complementary roles, that of the professional provider of treatment services and that of the peer providing recovery support services. People in these two roles might be thought of as working in partnership, sharing a common interest in the well being of the same individuals, guarding their medical safety, employing best practices, and promoting long-term recovery. Both roles are essential, and each completes the other. In many cases the exploration of these roles will not describe two distinct bodies of people, but

rather describe varying sets of skills that people use to guide their work, with some people combining skills from both roles.

It is our hope that addiction professionals and peer support providers alike will find this monograph valuable. May you find in it a little more clarity, many new ideas, a stronger sense of determination, and a far greater appreciation for the work that you and your counterparts do.

We wish to acknowledge and thank the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) for its ongoing support of these efforts and the opportunity to publish this important work. We also extend our gratitude to the Philadelphia Department of Behavioral Health and Mental Retardation Services, the Great Lakes Addiction Technology Transfer Center's partner in the publication of this document.

And our highest thanks go to our indefatigable author, William L. White. For the past 11 years, he has dedicated his life to seeing that this model—and the people whose lives depend upon it—have a chance for success. We are honored to do what we can to follow and support this quest.

Foreword

Arthur C. Evans, Jr., PhD, Director
Philadelphia Department of Behavioral Health and Mental Retardation
Services

Beverly J. Haberle, MHS, Executive Director
Bucks County Council on Alcoholism and Drug Dependence

Bill White has once again given readers a wonderful opportunity to walk through history and learn the healing power that is unleashed when Communities of Recovery work together for the common good. This monograph provides a foundation for those newly engaged in peer-based addiction recovery support activities. It also creates an opportunity for those already involved in providing these services to expand their thinking by exploring the diverse and innovative varieties of peer-based activities that are emerging in the field.

In Philadelphia, as in much of the nation, we are currently witnessing a reawakening of hope, vision, and purpose, as stakeholders call for and strive to implement sweeping changes in the manner in which addictions services are delivered. These changes go far beyond developing new programs or tweaking the ways in which existing services are structured. Recovery transformation is about creating more holistic systems of care that are consistent with what both scientists and people in recovery tell us works. Transformation moves us beyond efforts at short-term stabilization to helping individuals achieve sustained recovery, find meaningful roles in their communities, and fulfill their highest potential.

This monograph can be used as a tool kit to guide the design and delivery of peer-based support services in the context of Recovery Oriented Systems of Care. Included in this work are cautions, questions of ethics, and areas for further exploration. It also provides reassurance and validation that the hard work and careful planning required to implement peer-based and peer-delivered services can pay off in remarkable ways. Sometimes the simplest gesture of kindness and support at the right time by a peer produces tremendous positive change.

This monograph provided for us an opportunity to walk down “memory lane” and reflect on what has transpired during the past few years within the City of Philadelphia. To say, “Recovery is alive and well in the City of Brotherly Love” is an understatement. Philadelphia’s recovery transformation process has employed a participatory, collaborative approach at all levels, including full engagement of local community members, including people in recovery, in strategic planning and program development. Individuals and families in recovery have contributed their time and talents to identify unmet needs, solve problems, provide trainings, put a positive face on recovery to reduce stigma,

and deliver one-on-one services. Collectively, these efforts are expanding opportunities for individuals to initiate and sustain long-term recovery.

The Program Profiles are a highlight of this Monograph. These profiles outline different types of peer-based activities, projects, and services. In doing so, they not only provide readers with opportunities to visualize what the services look like and to explore their potential benefits, but they also help promote the development of a learning community by providing contact information so that readers can access additional information about any particular activity. This is an invaluable resource for communities starting peer-to-peer services. Sometimes it is difficult to grasp how peer-based services and activities actually operate. Bill White's Program Profiles give readers a glimpse of actual services and allow them to benefit from others' experience in creating new roles and functions. It is a testimony to the hard work of all involved in the Philadelphia Recovery Transformation that fifteen of the Program Profiles describe activities occurring within the City of Philadelphia. This would not be possible if it were not for the forward-thinking members of the recovery community and the tremendous collaboration that they have had with city officials and providers. This monograph reinforces the importance of having a broad-based approach that addresses the implementation of peer support services from multiple perspectives.

From a system administration perspective, this work is enormously important. Bill White has long championed the need for the field to shift from a professionally directed, acute-care model, with its focus on isolated treatment episodes, toward a sustained recovery management approach. In doing so, he has contributed significantly to the sense of urgency and energy that is currently stirring in the field. In this new monograph, White lays another critical building block in the foundation of system-transformation efforts. He masterfully describes how peer-based recovery support services (P-BRSS) can be used prior to, during, and following acute treatment to achieve the fundamental goal of care: recovery and a meaningful life in the community for everyone. Equipped with this monograph, leaders of the recovery community, providers, policy makers, and system administrators—that is, all those who grapple with how to make the vision of recovery a reality—now have access to the burgeoning scientific evidence that supports the critical role of peer-based recovery support services in addiction recovery.

System administrators and policy makers will find this monograph to be an invaluable resource. In addition to being armed with the scientific rationale to inform their decision-making, they will also have a better understanding of the infrastructure supports that will be necessary to create a seamless continuum of integrated P-BRSS and treatment services. Currently, many stakeholders are keenly aware of the tensions that naturally emerge between P-BRSS specialists and addiction professionals as concerns regarding roles and credibility challenge efforts at collaboration. By outlining the rich history and tradition of peer support within the addiction field, White reminds all stakeholders of the unique contributions that peer-directed services offer. In addition, his vivid Program Profiles take the concept of collaborative P-BRSS and professionally directed services from the realm of abstract aspirations to that of concrete strategies.

Finally, White's recommendations regarding a research agenda for P-BRSS represent some of the most urgent challenges confronting the field. He argues that the current pathology-focused research agenda needs to be expanded to include an exploration of the factors that promote recovery. While the research base for P-BRSS continues to grow, there remain significant gaps in what is known about how people recover, and specifically the role of P-BRSS in supporting recovery. To be successful in transforming our service systems, we will need to build learning communities based on relevant research, trust, mutual respect, and an understanding that the goal of recovery is not just important for people with substance use challenges and their families. Rather, the hope and realization of recovery touches every individual, family, and organization in our community. In this, another seminal work, Bill White tears down the walls that have existed between those providing peer-based recovery support and those offering professional treatment and, in doing so, charts a course toward more effective care, and more sustained recovery, for all.

The genius of this work is that it simultaneously speaks to the broad range of stakeholders in the addictions field, from those in the recovery community who are inspired to "give back," to systems administrators who are seeking to ensure the highest possible standard of service delivery.

Abstract

Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation

William L. White, MA

The history of addiction treatment and recovery in the United States contains a rich “wounded healer” tradition. For more than 275 years, individuals and families recovering from severe alcohol and other drug problems have provided peer-based recovery support (P-BRS) to sustain one another and to help those still suffering. Formal peer-based recovery support services (P-BRSS) are now being delivered through diverse organizations and roles. The goals of this monograph are to 1) define P-BRS and P-BRSS, 2) present a brief chronology of P-BRS in the United States, 3) discuss the theories and principles that guide the design and delivery of P-BRS services, 4) illustrate the current varieties of P-BRSS, and 5) review the scientific studies that have evaluated P-BRS and specialized P-BRSS. The monograph closes with a discussion of the strengths and vulnerabilities of peer-based recovery support and professionally directed addiction treatment services.

Key Words: Recovery mutual aid, recovery support services, recovery-oriented systems of care, recovery management, paraprofessional, ex-addict, recovery coach, peer, guide, recovery community, communities of recovery, sponsorship, recovery homes, recovery schools, recovery ministries, outreach.

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Introduction

SUMMARY OF KEY POINTS

- The organizing principle for providing care for people with alcohol and other drug problems is shifting from pathology and intervention paradigms to a long-term recovery paradigm.
- Evidence of this shift is seen in a shift in emphasis within addiction treatment from models of biopsychosocial stabilization to models of sustained recovery management.
- Recovery management models include assertive interventions to shorten addiction careers, lengthen recovery careers, and enhance the quality of individual/family life in long-term recovery.
- Peer-based recovery support (P-BRS) and formal peer-based recovery support services (P-BRSS) constitute central recovery management strategies and a core component of recovery-oriented systems of behavioral health care—with *system* here defined as a macro-level organization of a community, state, or nation.
- This monograph reviews the history, operational principles, service practices, and scientific status of P-BRS and P-BRSS and their future relationship with professionally directed addiction treatment.

THE RECOVERY MANAGEMENT MONOGRAPH SERIES

This is the seventh in a series of monographs on recovery management (RM) and recovery-oriented systems of care (ROSC). The first monograph, *Recovery Management*,¹ describes the emergence of recovery as an organizing paradigm for behavioral health services, reviews the varieties of recovery experience, outlines recovery management principles, and discusses recovery management within communities of color. The second monograph, *Special Report: A Unified Vision for the Prevention and Management of Substance Use Disorders*,² applies principles of chronic disease management to the treatment of severe alcohol and other drug (AOD) problems. The third monograph, *Linking Addiction Treatment and Communities of Recovery*,³ details empirically grounded strategies for linking addiction treatment clients to indigenous communities of recovery. The fourth monograph, *Perspectives on Systems Transformation*,⁴ is a

¹ White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management*. Chicago: Great Lakes Addiction Technology Transfer Center.

² Flaherty, M. (2006). *Special report: A unified vision for the prevention and management of substance use disorders*.

³ White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

⁴ White, W. (2007). *Perspectives on systems transformation*. Chicago: Great Lakes Addiction Technology Transfer Center.

collection of interviews with federal, state, and local leaders who are pioneering ROSC. The fifth monograph, *Recovery Management and Recovery-oriented Systems of Care*,⁵ defines and distinguishes recovery management and recovery-oriented systems of care, describes the changes in service practices that accompany the shift from acute care to sustained recovery management, and reviews the scientific evidence supporting the recovery management model. The sixth monograph, *Building the Science of Recovery*, outlines the scientific questions that must be answered to guide the future design of recovery-oriented systems of care.⁶

Collectively, these monographs portray an acute-care system of addiction treatment that has helped transform the lives of countless individuals and families, but whose potential benefits are often limited by serious design flaws. These design flaws can:

- inhibit client attraction, engagement, retention, and treatment completion;
- limit the scope and duration of professional services and recovery support provided during and following addiction treatment;
- fail to assertively link individuals and families to indigenous communities of recovery support;
- minimize the duration and intensity of post-treatment continuing care; and, as a result,
- generate high rates of post-treatment relapse and treatment re-admission.

Peer-based recovery support services (P-BRSS) are being designed to extend the current acute-care model of addiction treatment toward the singular goal of elevating long-term recovery outcomes. The strategies to achieve this goal broadly include pre-treatment, in-treatment, and post-treatment P-BRSS. Infrastructure support for these efforts include peer program standards development, peer training and certification initiatives, and regulatory changes that allow reimbursement of P-BRSS through Medicaid and Medicare and private managed behavioral health care entities.⁷ These activities are a product of the broader interest in the use of “community guides” to lead marginalized individuals and families back into full participation in community life.⁸

⁵ White, W. (2008). *Recovery management and recovery-oriented systems of care*. Chicago: Great Lakes Addiction Technology Transfer Center, Northeast Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

⁶ Laudet, A., Flaherty, M. & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.

⁷ Goldstrom, I.D., Campbell, J., Rogers, J.A., Lambert, D.B., Blacklow, B., Henderson, M.J., et al. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(1), 92-103. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

⁸ Davidson, L., Tondora, J., Staeheli, M., O’Connell, M., Frey, J., & Chinman, M. (2005). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community based clinical practice* (pp. 476-501). London: Oxford University Press. Loveland, D. & Boyle, M. (2005). *Manual for*

PURPOSE OF THE CURRENT MONOGRAPH

This seventh monograph provides a synthesis of current knowledge about the history, theoretical foundations, methods, and scientific status of peer-based recovery support services. This monograph is written primarily for those directly involved in planning, funding, delivering, supervising, and evaluating peer-based recovery support services. It is hoped that it will also find an audience among policymakers, purchasers of care, treatment program administrators, and addiction counselors and other service professionals. With such diverse readers, every effort has been made to present information in a clear and accessible language and to document meticulously the sources upon which conclusions and recommendations are based. The monograph introduces the reader to a lost body of literature on peer recovery support. I hope the unedited voices of these early pioneers will resonate with the contemporary reader. Program profiles are also included, most of them illustrating the varieties of peer recovery support services unfolding within one city (Philadelphia) as part of a larger recovery-focused behavioral health system-transformation process.

Also noteworthy is what is not included in this monograph. First, recovery advocacy as a medium of peer support is not addressed in this monograph because its recent history has been detailed in the author's book, *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*.⁹ Second, by focusing on peer recovery support for those with the most severe and complex alcohol and other drug (AOD) problems, this monograph does not extensively address the role of family and peer support in resolving AOD problems of lower severity and duration that are often resolved without formal professional or peer recovery support services. Readers interested in the role of peer support in the resolution of subclinical AOD problems are encouraged to explore the growing literature on *natural recovery*, *spontaneous remission*, *maturing out*, *autoremission*, and *self-initiated change*.

recovery coaching and personal recovery plan development. Retrieved August 18, 2008 from <http://www.bhrm.org/guidelines/RC%20Manual%20DASA%20edition%207-22-05.doc>. Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, 49(4), 550-561. White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor*, 5(6), 20-22. White, W. (2006). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity*. Philadelphia, PA: Philadelphia Department of Behavioral Health.

⁹ White, W. (2006). *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

A NOTE ON LANGUAGE

The development of recovery-oriented systems of care for individuals, families, and communities experiencing severe alcohol and other drug problems rests on new ideas, new policies, and new service practices. The shift in focus from pathology and intervention to long-term recovery is generating a new language that fills the monographs in this series. Our work to-date rests on the belief that words are important. Great care has been taken in selecting and defining such terms as *recovery*, *family recovery*, *recovery management*, *recovery-oriented systems of care*, *recovery capital*, *pathways of recovery*, *styles of recovery*, *recovery priming*, and *recovery coaching*—to name just a few.¹⁰

The present monograph presents two key terms. *Peer-based recovery support*, which will be designated by the acronym P-BRS, is a broad term referring to any form of mutual assistance directed toward the goal of long-term recovery from alcohol and other drug problems. Such assistance can and often does occur informally, particularly within recovery mutual-aid societies. *Peer-based recovery support services*, which will be designated by the acronym P-BRSS, is a narrower term for assistance toward the same goal that is delivered through more specialized roles with more formal resources, service protocols, and safeguards. The key distinction here is the term *services*, which implies a more formal structure through which recovery support is delivered. Discussions of P-BRS will focus primarily on recovery support provided through recovery mutual-aid societies and abstinence-based religious and cultural revitalization movements. Discussions of P-BRSS will focus primarily on recovery support provided through recovery community organizations other than recovery mutual-aid societies and through addiction treatment programs and allied health and human service agencies.

A CAUTION TO THE READER

There are many critical research questions about peer recovery support that have yet to be studied. Answers to-date for many questions are also tentative. This is a dynamic period in the development of these services. Caution is in order regarding the review of scientific studies of peer recovery support. Many of the cited studies suffer from methodological problems: convenient samples, small samples, lack of control groups and randomization, lack of follow-up, short periods of follow-up, and low follow-up rates, to name just a few. As with all research studies, the findings presented are best viewed as probationary, pending new studies of greater methodological sophistication.

¹⁰ White, W. (2001/2002). The rhetoric of recovery advocacy; An addiction recovery glossary: The languages of American communities of recovery. In: White, W. (2006). *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

Those on the front lines delivering peer support services and the individuals and families receiving these services do not have the luxury of waiting for needed studies. They must make the best decisions possible today based on what is now known. While this monograph seeks to convey present knowledge, it is crucial to recognize that this “best knowledge” is a living, evolving entity. Peer-based and other recovery support services, like professionally directed clinical services, are evolving in tandem with new scientific findings and the changing needs of those served. I look forward to the day when a fulfilled recovery research agenda will render this monograph obsolete.

Bill White
Senior Research Consultant
Chestnut Health Systems
Port Charlotte, Florida
January, 2009

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Chapter One

Defining Peer-based Recovery Support Services

SUMMARY OF KEY POINTS

Peer-Based Recovery Support:

- Peer-based recovery support (P-BRS) is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from alcohol and/or other drug-related problems.
- Peer-based recovery support is provided by people who are experientially credentialed.
- There are substantial differences between models of peer recovery support and models of professionally directed addiction treatment.
- P-BRS can be delivered through a variety of organizational venues and a variety of service roles (including paid and volunteer recovery support specialists).
- The governance structures of P-BRS vary in the span and degree of peer control (for example, peer-owned, peer-directed, and peer-delivered).

Peer-Based Recovery Support Services:

- Peer-based recovery support services (P-BRSS) are a form of P-BRS delivered through more formal organizations and through more specialized roles.
- Asset allocation schemes for P-BRSS include entrepreneur models (excess assets returned to private owner/investors), institutional models (excess assets reinvested in development of the organization), and stewardship models (excess assets reinvested in recovery community development).
- The core functions of P-BRSS span the stages of recovery initiation/stabilization, recovery maintenance, and enhancement of quality of life in long-term recovery and may encompass support at individual, family, neighborhood, and community levels.
- P-BRSS are distinguished by their recovery focus; mobilization of personal, family, and community recovery capital to support long-term recovery; respect for diverse pathways and styles of recovery; focus on immediate recovery-linked needs; use of self as a helping instrument; and emphasis on continuity of recovery support over time.
- P-BRSS may serve as an adjunct or alternative to professionally directed addiction treatment.

DEFINING PEER RECOVERY SUPPORT

There has been a recent proliferation of new forms of peer-based support to assist individuals and families in initiating and maintaining recovery from alcohol and other drug problems and enhancing the quality of personal/family life in long-term recovery. The advent of expanding sources of peer-based recovery support (P-BRS) and new roles specializing in the delivery of peer-based recovery support services (P-BRSS) calls for increased definition of these functions and roles. The following definition of P-BRS is offered as a starting point for discussion.

Peer-based recovery support is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

This definition contains several critical elements.

Peer-based means that the supports and services are drawn from the experience of individuals who have successfully achieved addiction recovery and/or who share other characteristics (for example, age, gender, ethnicity, sexual orientation, co-occurring disorders, prior prison experience, family experience, or other identity-shaping life experiences) that enhance the service recipient's sense of mutual identification, trust, confidence, and safety. What constitutes *peer* is defined by each individual, rather than by an organization. The reference to *peer-based* implies that services are provided by peers and that peers play an important role in the design, development, delivery, and evaluation of services. To further clarify this point, individuals seeking recovery may receive peer support within a therapy group led by a professional therapist within an addiction treatment organization, but this would not be considered a peer-based recovery support service.

Recovery support distinguishes the singular goal toward which all efforts are directed. *Recovery*, as used in this monograph, involves three critical elements: 1) sobriety (abstinence from alcohol, tobacco, and unprescribed drugs), 2) improvement in global health (physical, emotional, relational, and ontological—life meaning and purpose), and citizenship (positive participation in and contribution to community life).¹¹ *Support* involves the provision of informational, emotional, social, and/or material aid.

Process implies that the assistance is not a single event or activity and is relational rather than mechanical, and that continuity of support over the time is central to the desired outcome of long-term recovery.

¹¹ For discussions about the role of citizenship in recovery and the meaning of recovery, see: The Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228; White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

Non-professional means that the P-BRS relationship is closer to the reciprocity of friendship than the fiduciary relationship one has with a physician, lawyer, banker, psychologist, or social worker. The power differential in the relationship between peers is minimal compared to the power differential that characterizes professional service relationships. Many P-BRSS specialists are also *indigenous non-professionals*, meaning that they claim membership and are viewed as members of the group being served, and their activities are valued because of their personal history and social position within a constituent community.¹² P-BRSS specialists see those they serve, not as different from themselves, but as one of “my people”—“brothers and sisters” to whom they are connected by a “kinship of common suffering”¹³ and a kinship of gratitude, hope, and shared purpose.

Non-clinical distinguishes P-BRS from clinical services that involve diagnosis and treatment by health care professionals. Addiction professionals and other professionals in recovery—christened “bridge people” by Bissell¹⁴—may volunteer to provide P-BRSS, but they are not acting in their professional capacity or providing professional services when they are in this role. Professional, clinically-based services may have a peer quality to them when they are delivered by physicians, nurses, psychologists, social workers, or addiction counselors who are in recovery. However, such services are not considered P-BRSS as defined in this monograph. *Non-clinical*, in addition to designating who is providing the service, also denotes what is being provided: the more general categories of informational, emotional, social, and instrumental (practical assistance such as transportation) support.¹⁵ Two other distinctions are noteworthy. Where clinically oriented addiction treatment often values the experience of emotional catharsis, P-BRS extols the value of emotional control. Where clinically oriented addiction treatment services may focus inward on personal wounds, P-BRS involves a focus outward—on connecting with resources and relationships beyond the self.

The phrase *experientially credentialed* means that the knowledge drawn on to provide P-BRS is acquired through life experience rather than formal education. It is first hand rather than second hand. It means that peer support specialists understand long-term recovery as a “lived experience” and can offer

¹² Pearl, A. (1981). The paraprofessional in human service. In S. Robbin & W. Wagonfeld (Eds.), *Paraprofessionals in the human services*. New York: Human Science Press. Reiff, R. & Reissman, F. (1965). The indigenous nonprofessional: A strategy of change in community action and community mental health programs. *Community Mental Health Journal*, Monograph No. 1. Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, 49(4), 550-561.

¹³ Alcoholics Anonymous (1957). *Alcoholics Anonymous comes of age*. New York: A.A. World Services, Inc.

¹⁴ Bissell, L. (1982). Recovered Alcoholic Counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

¹⁵ Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401; Emerging peer recovery support services and indicators of quality: An RCSP Conference report, September 2006, Substance Abuse and Mental Health Services Administration.

guidance on the nuances of this experience as it unfolds over time. Their authority, sometimes referred to as “street credentials,” comes from their own healing journey, their history of recovery service work with others, and their tenured membership within a community of recovering people. Most, but not all, persons providing P-BRS have experienced recovery personally or as a family member.

Experiential knowledge comes from having experienced, lived with, or done battle with addiction and from having participated in one’s own or other’s recovery. This does not explicitly require that all volunteer or paid support staff be recovered or recovering, but it does require that they have learned about addiction and recovery from close proximity. Experiential expertise requires the ability to use this knowledge to affect change in self or others. This latter credential—granted through the community “wire” or “grapevine” (community story-telling)—bestows credibility that no university can grant. It is bestowed only on those who offer sustained proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes, not from their preparation, but from their own life history, character, relationships, and performance within the community.¹⁶

Experiential knowledge does not mean that the P-BRSS specialist does not need training or supervision, but it does affirm life experience as the foundational source drawn upon in the helping process.

Assistance implies a broad spectrum of support activities—whatever it takes—rather than the more specialized service menus offered by professional helpers. Non-clinical, peer-based recovery support can be delivered through the framework of a recovery mutual-aid society or a community-based service or advocacy organization, or within a larger religious or cultural revitalization movement.

The phrases *long-term recovery* and *in initiating recovery, maintaining recovery, and enhancing one’s quality of life in recovery* underscore the vision of P-BRSS as long-term availability and support, as opposed to brief, crisis-oriented biopsychosocial stabilization. The implicit focus is on moving beyond reducing addiction-related pathology to building sustainable personal, family, and community recovery capital. This is a vision of global health (wellness), life meaning and purpose, and enhanced service to community. It reflects the view that long-term recovery is far more than the alleviation of alcohol and drug problems from an otherwise unchanged life.

The phrase *from alcohol and/or other drug-related problems* defines the boundaries of experiential competence and suggests that the support services offered may not be appropriate for individuals and families experiencing problems outside this arena. It also conveys that P-BRSS encompass the whole

¹⁶ White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, 26(3), 365-395.

spectrum of AOD-related problems and not just those that meet criteria for severe alcohol or drug dependence.

In speaking of peer-based recovery support services (P-BRSS), the term *service* as used in this monograph will reflect a unit of activity provided by a formal helping institution rather than the “service work” that is a common dimension of personal recovery across religious, spiritual, and secular pathways of recovery. Peer-based recovery support (P-BRS) is used as an umbrella term for all forms of mutual recovery support, including those provided informally or through a recovery mutual aid group. Peer-based recovery support services (P-BRSS) will be used to designate those peer supports that are organized into formal services and delivered through more formal organizations. The distinction will be important as we later attempt to distinguish the recovery support provided by an addiction counselor or a 12-Step sponsor from that provided through the role of a recovery coach or other recovery support specialist.

DISTINGUISHING PROFESSIONAL AND PEER SUPPORT

Robert Emrick, a sociologist who has investigated peer support groups, notes the “natural antithesis between the philosophies of self-help and professional health care.”¹⁷ Emrick and others see several crucial differences between peer and professional models of support. Some of these key differences and the vulnerabilities resulting from them are briefly summarized in Table 1.¹⁸ These represent generalizations about opposite models/philosophies that exist at either end of a long continuum. For any given individual or organization, actual modes of operation may lie anywhere along that continuum. However, an understanding of these two poles helps us understand some of the forces that have helped shape these services and the vulnerabilities they have created.

¹⁷ Emerick, R.E. (1990). Self-help groups for former patients: Relations with mental health professionals. *Hospital and Community Psychiatry*, 41(4), 401-407.

¹⁸ This table is based on the work of the following: Emerick, R.E. (1990). Self-help groups for former patients: Relations with mental health professionals. *Hospital and Community Psychiatry*, 41(4), 401-407.; Gartner, A.J. (1997). Professionals and self-help. *Social Policy*, 27(3), 47-52; White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

Table 1: Professional and Peer Models of Helping

Helping Dimension	Professional	Vulnerability	Peer	Vulnerability
Source of Knowledge	Scientific knowledge presented in form of theories, empirical studies, and objective analysis.	Mistake knowledge gained from limited studies within a single paradigm for the whole truth.	Experiential knowledge drawn from historical and personal experience.	Mistake limited personal experience for the whole truth.
Control of Knowledge	Knowledge carefully controlled, often presented in arcane language, and protected.	Danger of closed ideological system investigating only questions that will not threaten the system and whose answers are already known; pathology-focused language contributes to social stigma.	Knowledge freely available and widely shared.	Anti-intellectualism; folk knowledge can be hijacked, corrupted, and commercialized by external institutions.
Role boundaries	Extreme separation of helper and helpee roles; emphasis on professional distance and objectivity.	Under-involvement; detachment and clinical abandonment.	Helper and helpee roles are reciprocal; emphasis on relational connection and personal involvement.	Over-involvement; injury to helpee and helper through excessive intimacy.

Helping Dimension	Professional	Vulnerability	Peer	Vulnerability
Structure of helping	Significant power differential between helper and helpee; extensive legal, regulatory, and ethical guidelines govern relationship; high external accountability; extensive record-keeping; limited accessibility; fees attached to services; considerable organizational hierarchy; helping as a commodity.	Helping procedures and personal and institutional interests can become more important than helping relationship and helping outcomes.	Minimum power differential between helper and helpee; helping relationship governed only by internal guidelines and group conscience; minimal if any records; low external accountability; high accessibility; services available without fees; minimal organizational hierarchy; helping as a commitment.	Exploitation of power inequities is possible in the peer context with no mechanisms for redress; over-extension of the helper; risk of organizational collapse; range of services limited by lack of financial resources.
Helping focus	Clinical orientation emphasizes “getting into oneself”; clinician is in control of degree of intimacy.	Approach can be personally invasive; tendency to define problems and solutions solely in personal rather than political or cultural terms.	Support focus is often on “getting out of oneself”—connecting with resources and relationships beyond the self; helpee controls degree of intimacy.	Those groups that emphasize politicizing their members may provide inadequate personal support.

It can be seen from this table that the differences between professional and peer models of helping are extensive. Steve Hornberger of the National Association for Children of Alcoholics suggests this professional/peer tension is similarly evident within efforts to move from provider-driven service models to family-driven service models.¹⁹ Many reviewers of this monograph aptly noted that the distinctions between peer and professional models have blurred within the addiction field over the past four decades, and that this influence is reciprocal, with professional treatment exerting considerable influence on the content and style of recovery support meetings and recovery support fellowships exerting considerable influence on addiction treatment and addiction counseling. Such

¹⁹ Steve Hornberger, personal communication, January, 2009; also see: Osher, W. and Osher, D. (2002). The paradigm shift to true collaboration with families. *Journal of Child and Family Studies*, 11(2), 47-60.

reciprocity of influence might be viewed as a healthy synergy or as a corruption and loss of the unique dimensions of both forms of helping.²⁰

CORE CHARACTERISTICS OF P-BRSS SPECIALISTS

Looking at the ideal characteristics of a P-BRSS specialist (someone who provides P-BRSS) is one way to think about what distinguishes people providing these non-clinical services from outreach workers, case managers, or addiction counselors, as well as from recovery mutual-aid sponsors. The defining characteristics of P-BRSS are illustrated in Table 2. This Table further implies some of the potential differences between peer models of recovery support and professional models of addiction treatment.

Table 2: Defining Characteristics of P-BRSS

Role Dimension	Defining Characteristics of P-BRSS Specialist
Recovery Orientation	Focus on long-term recovery rather than brief biopsychosocial stabilization; focus on full recovery rather than remission; working across multiple (religious, spiritual, secular, cultural) frameworks of recovery rather than within a particular framework; emphasis on a person's self-determination and service philosophy emphasizing personal choice.
Strengths-based	Focus on individual strengths and enhancement of recovery capital via enmeshing individuals/families in a "culture of health" rather than focusing on disease and disability; ²¹ orientation toward potential rather than toward problems. ²²

²⁰ For concerns about negative influence of professional treatment on AA, see: Kurtz, E. (1999). *The Collected Ernie Kurtz*. Wheeling, WV: The Bishop of Books, pp. 131-141; For concerns about negative influence of AA on professional treatment, See Kalb, M. & Proper, M.S. (1976). The future of alcoholology: Craft or science. *American Journal of Psychiatry*, 133(6), 641-645.

²¹ Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134-41.

²² Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.). *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman.

Role Dimension	Defining Characteristics of P-BRSS Specialist
Ecology of Recovery	Focus more interpersonal than intrapersonal; emphasis on building individual, family, and community recovery capital; assertive efforts to design and deliver family-focused P-BRSS.
Core Knowledge	Pathways, styles, and stages of long-term recovery; ecology of recovery; organizational structure, core ideas, language, and meeting rituals of local communities of recovery; service protocols of recovery community institutions; indigenous and formal support within larger community.
Core Skills	Engagement, motivational enhancement, recovery planning; ²³ liaison with communities of recovery; assertive linkage between indigenous and formal recovery supports; lapse and relapse intervention; recovery education; recovery checkups and coaching; recovery resource development; reputation maintenance within communities of recovery; ability to access mainstream institutions; generalist rather than specialist role in recovery support.
Temporal Orientation	Focus on the present, next steps, and near future rather than focus on feelings about past personal experience.
Motivational Fulcrum	Hope-based rather than pain-based motivational strategies, attracting people to recovery based on what recovery can add to one's life rather than on what painful consequences can be escaped.
Use of Self	Strategic use of one's own story; making recovery contagious via energy and example; relating, not out of a position of expertise, superiority, or objectivity, but out of mutual identification and humility ("there but for the Grace of God go I"), ²⁴ striving for invisibility while deflecting praise and leadership opportunities to others in the community.
Service Vision	Long-term personal/family/community recovery; growth of individual/family/community recovery capital.

²³ See Borkman, 1998, for distinction between recovery planning and treatment planning.
Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, 15(1), 37-42.

²⁴ Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

Role Dimension	Defining Characteristics of P-BRSS Specialist
Roles of Professional Treatment and Community in Recovery	Professionalized services not viewed as the first line of response to need, but as a safety net for needs that cannot be met by natural community (relationships that are non-hierarchical, enduring, and non-financial); P-BRSS specialist immersed in community life; community invited to support individuals/families in recovery.
Community Education	Every opportunity used to educate the community about addiction recovery at personal, family, and community levels; shifts pathology-focused discussions within the community to solution-focused discussions; raises awareness of the approximately 90% of persons with AOD problems not seen in professional treatment.
Community Development	Role combines personal/family recovery support functions with recovery-focused community organization and cultural renewal/revitalization functions.
Advocacy	Assertive advocacy on recovery-related issues that transcend personal, professional, and institutional interests.; advocacy to reduce/eliminate service disparities; reduce/eliminate stigma/discrimination; and make addiction treatment more responsive, effective, and efficient.
Empowerment	Recovering people play key roles in governance of service organizations; emphasis on voluntary consent for participation in P-BRSS; choice and self-determination highly valued; P-BRSS role seen as non-hierarchical and catalytic rather than directive; support for advocacy on one's own behalf; linkage to recovery leadership development opportunities; self-monitoring to avoid "freezing clients in dependent roles." ²⁵
Degree of Personal Involvement	High degree of personal involvement: "There are things he [the indigenous nonprofessional] can do which the professional is not able to do and should not do....He can be invited to weddings, parties, funerals and other gatherings—and he can go." ²⁶
Fidelity and Endurance	Continuity of contact with individuals, families, and community institutions over a sustained period of time.

²⁵ Dhand, A. (2006). The roles performed by peer educators during outreach among heroin addicts in India: ethnographic insights. *Social Science of Medicine*, 63(10), 2674-85.

²⁶ Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

VARIETIES OF PEER RECOVERY SUPPORT SERVICES

P-BRSS are being delivered within a variety of organizational contexts, including recovery mutual-aid societies; addiction treatment programs; recovery community organizations; and allied health, child welfare, and criminal justice systems. These service-delivery organizations—spanning volunteer, not-for-profit, and for-profit entities—vary widely in their degree of connection to local communities of recovery.

Governance of organizations that provide recovery support involves control of organizational policies and the ways in which organizational assets are best invested to increase recovery outcomes. P-BRSS may be provided through:

- entrepreneur models in which excess assets of the organization are returned to private owner/investors in the form of profit,
- institutional models in which excess assets are reinvested in development of the organization, or
- recovery community development models in which excess assets are reinvested in projects that enhance the service work of local communities of recovery.

People performing P-BRSS roles are being variably referred to as sponsors, peer helpers, peer specialists, peer educators, peer mentors, outreach workers, residential managers, community guides, recovery coaches, recovery assistants, recovery support specialists, recovery escorts, recovery consultants, prosumers, recovery mentors, ombudsmen, and behavioral health paraprofessionals. While titles such as peer counselor or counseling aid are also sometimes used, they can be confusing because they heighten the level of ambiguity in the demarcation between professional treatment services and non-clinical recovery support services. As will be evident as we proceed through this monograph, it is important to distinguish clearly the roles of the P-BRSS specialist, the recovery mutual-aid sponsor, and the addiction counselor.²⁷

Table 3 (following page) summarizes some of the key dimensions of peer recovery support and how these dimensions vary dramatically from organization to organization. We will return to some of these dimensions shortly for a more in-depth discussion.

²⁷ Clark, H.W. (1987). On professional therapists and Alcoholics Anonymous. *Journal of Psychoactive Drugs*, 19(3), 232-42. Doyle, K. (1997). Substance abuse counselors in recovery: Implications for the ethical issue of dual relationships. *Journal of Counseling and Development*, 75, 428-432. White, W. (2006). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity*. Philadelphia, PA: Philadelphia Department of Behavioral Health.

Table 3: Defining Characteristics of Organizations Delivering P-BRSS

Dimension	Varieties
Repsource Accrual and Allocation	A. Assets accrue as profits to owner(s)/investor(s) B. Assets are fed back into organization to support and expand support activities
Governance	A. Peers make major organizational decisions,, with accountability to one or more communities of recovery B. Peers can advise on organizational decisions; no accountability to communities of recovery C. Peers have no role in organizational decisions; accountability to communities of recovery
Problem Perception	A. Rooted in the person (Intrapersonal Model) B. Rooted in disturbed relationships (Interpersonal Model) C. Rooted in historical trauma/environmental conditions (Social Change Model)
Ideological Orientation	A. Religious B. Spiritual C. Secular D. Mixed
Method of Problem Resolution	A. Abstinence-based B. Moderation-based C. Medication-assisted
Relationship with Professionals	A. Professional Leadership (professionals serve as founders and group leaders) B. Professional Consultation (group is led by peers but has professionals available for consultation and support) C. Professional Collaboration Model (group is led by peers but works with other professionals in the community) D. No professional leadership E. Anti-professional
External Relationships	A. Closed System (thick organizational boundaries, aggressive gatekeeping, strict membership criteria to enhance mutual identification, isolation from community, expectation of confidentiality, anonymity at level of press) B. Open System (diffuse organizational boundaries, minimal gatekeeping, loose and evolving membership criteria, high levels of community interaction, leaders and members visible to larger community)
Internal Relationships	A. Face-to-face B. Telephone-based (voice and/or text) C. Internet-based D. Mixed
Service Roles	A. Peer support provided on a volunteer basis B. Peer support provided on a paid basis C. Peer support provided through a combination of volunteer and paid roles.

What distinguishes quality of peer recovery support services has been a focus of increasing discussion. In a 2005 meeting of the Center for Substance

Abuse Treatment's Recovery Community Services Program, 28 grantees defined 12 criteria they viewed as quality indicators.

1. Peer recovery support services are clearly defined in ways that differentiate them from professional treatment services and from sponsorship in 12-Step or other mutual-aid groups.
2. The programs and peer recovery support services are authentically peer based (participatory, peer led, and peer driven) in design and operation.
3. The peer recovery support program has well delineated processes for engaging and retaining a pool of peer leaders who reflect the diversity of the community and of people seeking recovery support.
4. The peer recovery support program has an intentional focus on leadership development.
5. The peer recovery support program operates within an ethical framework that reflects peer and recovery values.
6. The peer recovery support program incorporates principles of self-care, which are modeled by staff and peer leaders, and has a well considered process for handling relapse.
7. The peer program and peer recovery support services are nonstigmatizing, inclusive, and strengths-based.
8. The peer recovery support program honors the cultural practices of all participants and incorporates cultural strengths into the recovery process.
9. The peer recovery support program connects peers with other community resources irrespective of types of services offered.
10. The peer recovery support program has well established, mutually supportive relationships with key stakeholders.
11. The peer recovery support program has a plan to sustain itself.
12. The peer recovery support program has well documented governance, fiscal, and risk management practices to support its efforts.²⁸

CORE FUNCTIONS

The functions of the P-BRSS specialist vary widely by role, clientele, and organizational setting, but collectively reflect the following functions:

- Assertive outreach to identify and engage those in need of recovery—what Malcolm X referred to as “fishing for the dead”²⁹ and Reiff and Riessman³⁰ called “reaching the hitherto unreached”

²⁸ Kaplan, L., *The role of recovery support services in recovery-oriented systems of care*. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration, 2008, pp. 19-20.

²⁹ Myers, W.D. (1993). *Malcolm X: By any means necessary*. New York: Scholastic.

³⁰ Reiff, R. & Riessman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*, Monograph No. 1.

- Minimization of harm to self, family, and community in the transitions through identification, engagement, destabilization of addiction, and recovery initiation
- Recovery capital/needs assessment for individual/family/community
- Recovery education and coaching for individual/family (normative recovery information, encouragement, support, and companionship; enhancement of recovery self-management skills), often delivered in the natural environment of the individual/family
- Community-level recovery education
- Recovery resource identification, mapping, and development, including volunteer recruitment
- Recovery resource mobilization (activating a state of readiness to respond to the needs of an individual/family at a particular point in time)
- Community-level recovery resource development
- Assertive linkage to communities of recovery (support groups and support institutions)
- Assertive linkage to and systems navigation within addiction treatment and allied human services
- Liaison (bridging, brokering/negotiating, partnering) between individual, family, organization, and community
- Recovery-focused skill training aimed at full community participation (education, employment, housing, leisure, worship and pro-recovery family and social relationships)
- Companionship and modeling of recovery lifestyle, including participation in leisure activities that would be judged a breach of ethics for addiction counselors, e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event³¹
- Problem-solving to eliminate obstacles to recovery, e.g., linkage to resources for child-care, transportation, community re-entry from jail/prison
- Recovery check-ups (sustained monitoring, support/companionship, and recovery promotion)
- Recovery advocacy for individual/family needs (empower individuals and family members to assert their rights and needs)
- Recovery advocacy for aggregate community needs
- Recovery leadership development
- Conducting a regular self-inventory of personal and organizational performance via reflection, dialogue with service constituents, and analysis of recovery-focused service benchmark data

³¹ Wolf and Kerr (1979) recommended such activities under the rubric of “companionship therapy,” as a means of lowering post-treatment relapse rates. Wolf, K. & Kerr, D.M. (1979). Companionship therapy in the treatment of drug dependency. In B. S. Brown (ed.), *Addicts and aftercare* (pp. 183-209). Beverly Hills, CA: Sage.

These core functions can be divided into four overlapping stages of recovery support: 1) pre-recovery engagement, 2) recovery initiation and stabilization, 3) recovery maintenance, and 4) enhancement of quality of life in long-term recovery. (One advantage of this staged view of recovery is that it provides a way to transcend the traditional polarization between harm reduction and treatment interventions.) These same functions also encompass different “zones of action and experience” in recovery: physical, psychological (cognitive/emotional), relational, occupational/leisure, and ontological (spirituality/life meaning and purpose).³²

TREATMENT ADJUNCT OR ALTERNATIVE

As noted, P-BRSS can constitute an adjunct or alternative to professionally directed addiction treatment. The former is often demarcated by:

- pre-treatment P-BRSS (services aimed at identification, relational engagement, motivational enhancement, and treatment entry),
- in-treatment P-BRSS (services aimed at enhancing service quality, continued participation, and treatment completion), and
- post-treatment P-BRSS (services focused on post-treatment recovery checkups, stage-appropriate recovery education, assertive linkage to communities of recovery, early re-intervention, and coaching for enhanced quality of personal/family life in long-term recovery).

Although P-BRSS will never and should never fully replace professionally directed treatment as a means of initiating recovery, P-BRSS can serve as an alternative to treatment for people with low to moderate problem severity and high levels of personal, family, and community recovery capital.³³ P-BRSS may also serve as an alternative for relapsed clients with multiple prior treatment episodes who have mastered the art of initiating recovery through the vehicle of professional treatment but are unable to sustain recovery within their natural environments following discharge from treatment.

Recovery support in the professional literature is very much focused on treatment, but pre-recovery engagement entails far more than the question of how to link someone to treatment, and post-treatment peer support services involve far more than maintaining the improvements made in treatment. P-BRSS involve a larger spectrum of life concerns than those typically addressed in addiction treatment, including basic necessities of living, reconstruction of

³² There are many staged models of recovery that are reviewed by White & Kurtz, 2006, but Rossi’s depiction of these as sobriety, happy sobriety, and healthy sobriety is as apt here as any. White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

³³ White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27.

personal lifestyle, sober fellowship and leisure activities, restitution and community service, and life meaning and purpose. Where treatment focuses on the problems that can be subtracted from the client's life, P-BRSS focus on what can be added during long-term recovery.

In the next chapter, we will explore the history of peer-based addiction recovery support from the mid-1700s to the present.

Chapter Two

History of Peer-Based Recovery Support Services

SUMMARY OF KEY POINTS

- Addiction recovery mutual-aid societies and the specialty sector of addiction treatment emerged in response to the social stigma attached to AOD problems³⁴ and the history of service exclusion, service extrusion, and ineffective and harmful interventions³⁵ that individuals and families experienced in their encounters with mainstream health and human service institutions.
- Addiction recovery mutual-aid societies have experienced substantial growth (membership size and geographical dispersion of local meetings), pathway diversification (secular, spiritual, and religious recovery societies), specialization (meetings focused on age, gender, drug choice, and special needs), and new support media (growth of telephone- and Internet-based support).
- A growing number of religious and cultural revitalization movements are embracing abstinence, creating unique cultural and religious pathways of recovery initiation and recovery maintenance.
- People in recovery have sought service roles as a natural extension of the service ethic within communities of recovery and as a backlash against ineffective and disrespectful professional interventions.
- The services recovering people have provided to individuals and families suffering from AOD problems have emphasized service relationships that are natural, equal, reciprocal, voluntary, sustained (potentially life-long), non-bureaucratic, and non-commercialized.
- P-BRSS constitute an effort to recapture dimensions of support lost in the professionalization of addiction counseling and the weakening of the

³⁴ For information on how this stigma influenced attitudes of mainstream service professionals, see: Goodyear, R. (1983). Patterns of counselors' attitudes toward disability groups. *Rehabilitation Counseling Bulletin*, 1, 181-184. Grob, G. (Ed.) (1981). *Nineteenth-Century medical attitudes toward alcoholic addiction*. NY: Arno Press. Haberman, P.W. & Sheinberg, J. (1969). Public attitudes toward alcoholism as an illness. *American Journal of Public Health*, 59, 1209-1216. Hayman, M. (1956). Current attitudes to alcoholism of psychiatrists in southern California. *American Journal of Psychiatry*, 112, 485-493. Schneider, C. & Anderson, W. (1980). Attitudes toward the stigmatized: Some insights from recent research. *Rehabilitation Counseling Bulletin*, 23(4), 299-311.

³⁵ For a recent review of the harm done in the name of help within the history of addiction treatment, see White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals. *Counselor*. 9(6), 10-17.

service ethic within communities of recovery that accompanied the rise of an “alcohol and drug abuse industrial complex.”³⁶

- People in recovery have been cyclically included and excluded from leadership and service roles within addiction treatment and the broader arena of recovery support services.
- Recovering people are awakening politically and culturally and are generating new recovery support institutions that complement and, in some circumstances, compete with professionally directed addiction treatment.
- New recovery support institutions include grassroots recovery community organizations, recovery homes and colonies, recovery industries, recovery schools, recovery ministries and recovery churches, recovery-focused media (radio, television, cinema), and recovery arts (music, literature, film, comedy).
- Recovering people are again moving into a broad range of service roles within addiction treatment and allied health care, human service, and criminal justice agencies.
- Recovery support services are being rapidly privatized and professionalized—a trend with unclear long-term consequences.

The history of peer-based recovery support in the United States spans the services of solo practitioners, recovery support within larger religious/cultural revitalization movements, formal recovery mutual-aid societies, recovery social clubs, recovery community service institutions, recovering people working in non-professional support roles in addiction treatment and prevention organizations, recovering people working in professional roles in addiction treatment, and recovering people working in allied service organizations. This history has been presented elsewhere in considerable depth.³⁷ For purposes of this monograph, we will provide a brief summary of peer-based recovery support structures in the United States.

It is important to put this in context. There would be no history of recovery mutual-aid societies, and no history of addiction treatment, if people

³⁶ Hughes, H. (1974, December). *Address before the North American Congress on Alcohol and Drug Problems*. San Francisco, CA.

³⁷ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2000a). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, 18(1), 1-23. White, W. (2000b). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly*, 18(2), 1-25. White, W. (2000c). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases*, 19(2), 1-10. White, W. (2004a). *The history and future of peer-based addiction recovery support services*. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Posted at: http://www.facesandvoicesofrecovery.org/pdf/peer-based_recovery.pdf. Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

seeking recovery had found support for recovery within their natural communities and if they had received respect and effective professional help from other health and human service institutions. Historically, recovery mutual-aid movements rise in the absence, under-funding, ineffectiveness, or collapse of professional systems of care.

It is under such circumstances that recovering people turn to one another, discover that they can do together what they are failing to do alone, and conclude that their methods are superior to other methods. The source of any subsequent failure is viewed as rooted within the person rather than in the program.³⁸ The anti-professionalism that sometimes characterizes recovery mutual-aid movements is rooted in recovering peoples' experience of contempt, service exclusion, service ineffectiveness, and harm done in the name of help within mainstream health and human service institutions.³⁹

This collective experience of people with AOD problems set the stage for the rise of addiction recovery support groups and the specialized field of addiction treatment.⁴⁰ Historically, traditionally trained helping professionals (physicians, psychiatrists, nurses, psychologists, social workers) enter the field of addiction treatment in large numbers only during periods of increased funding and heightened professional status. When the stigma attached to addiction treatment and recovery rises again, with resulting cutbacks in funding and status, traditional professionals tend to abandon the addictions field for more financially and socially attractive opportunities.

When systems of support and care for addiction recovery collapse, it is recovering people and their families and a small cadre of committed professionals who join together to birth new systems of support and care. In each cycle, such care and support evolve from peer-based to professional-based models, resulting in transition periods of mixed peer/professional characteristics. The therapeutic community, for example, began as a purely peer-based model of recovery and evolved into a professional treatment that retained strong peer elements. The stigma experienced by people in medication-assisted recovery (particularly persons enrolled in methadone maintenance) when they seek involvement in traditional recovery support groups (e.g., Narcotics Anonymous) has led to alternative support groups that mix peer and professional support characteristics.⁴¹ Similarly, SMART Recovery® is usually referred to as a peer

³⁸ Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher. Toch, H. (1965). *The social psychology of social movements*. Indianapolis: Bobbs-Merrill.

³⁹ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁴⁰ For a discussion of the aversion to alcoholics/addicts among mainstream service professionals, see: Googins, B. (1984). The avoidance of the alcoholic client. *Social Work*, 29, 161-166. White, W. (2003b). A history of contempt: Countertransference and the dangers of service integration. *Counselor*, 4(6), 20-23.

⁴¹ Nurco, D.N., Stephenson, P., & Hanlon, T.E. (1991). Contemporary issues in drug abuse treatment linkage with self-help groups. In R. W. Pickens, C. G. Leukefeld, & C. D. Schuster (Eds.), *Improving drug abuse treatment* (NIDA Research Monograph, 106; pp. 338-348). Rockville, MD: National Institute on Drug Abuse.

recovery support program but continues to use professional facilitators for many of its meetings.

The following discussions outline the history of peer-based models of recovery support.

SOLO PRACTITIONERS

People recovering from alcohol and other drug addictions have a long history of reaching out to others similarly afflicted. Solo practitioners pursue this outreach in relative isolation from other organized frameworks of recovery support. Most often, they do so to bolster their own recovery and to fulfill a newfound calling to help others. In the nineteenth century, such persons traveled from town to town giving temperance lectures, providing personal consultations to inebriates and their families, organizing local recovery support meetings, and maintaining a prolific correspondence with those seeking recovery.

This style of recovery evangelism is well illustrated in the biographies of nineteenth-century temperance missionaries John Hawkins,⁴² John Gough,⁴³ Edward Uniacke,⁴⁴ George Dutcher,⁴⁵ Luther Benson,⁴⁶ and Thomas Doughty.⁴⁷ These accounts attest to the special kinship that existed between the “reformed reformers” and those still suffering addiction to strong drink.⁴⁸

*I can sympathize with and appreciate the condition of the poor inebriate. Have I not been one of their number? I now have an object in life—to reform men.*⁴⁹

They [reformed men] understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard's heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform... (from the Mercantile Journal, May 27, 1841.⁵⁰)

⁴² Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.

⁴³ Gough, J. (1870). *Autobiography and personal recollections of John B. Gough*. Springfield, MA: Bill, Nichols & Company.

⁴⁴ Berry, J. (1871). *UNIACK: His life, struggle, and fall*. Boston, MA: Alfred Mudge & Son.

⁴⁵ Dutcher, G. (1872). *Disenthralled: A story of my life*. Hartford, Connecticut: Columbian Book Company.

⁴⁶ Benson, L. (1896). *Fifteen years in hell: An autobiography*. Indianapolis: Douglas & Carlton.

⁴⁷ Doughty, T. (1903). *Thomas Doughty: His life, struggle and triumph*. Battle Creek, MI: The Gage Printing Company, Limited.

⁴⁸ A Member of the Society. (1842). *The foundation, progress and principles of the Washingtonian Temperance Society of Baltimore, and the influence it has had on the temperance movements in the United States*. Baltimore: John D. Toy.

⁴⁹ Doughty, T. (1903). *Thomas Doughty: His life, struggle and triumph*. Battle Creek, MI: The Gage Printing Company, Limited.

⁵⁰ Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.

The relapse rate was high for those not linked to a recovery mutual-aid society. Luther Benson, like many solo practitioners, relapsed repeatedly during his career as a temperance missionary. With each relapse, he threw himself more intensely into the work in the hope it would take the place of alcohol. Following his admission to the Indiana Asylum for the Insane in 1896, Benson reflected on this failed strategy.

*I learned too late that this was the very worst thing I could have done. I was all the time expending the very strength I so much needed for the restoration of my shattered system.*⁵¹

People who experience recovery outside professional treatment or mutual-aid groups have continued this recovery missionary tradition as solo practitioners. There are fewer such solo practitioners today due to the number of competing recovery support structures, but if such structures should ever collapse, solo recovery advocates would quickly rise to fill this void.

PEER RECOVERY SUPPORT AND RELIGIOUS/CULTURAL REVITALIZATION MOVEMENTS

Abstinence-based religious and cultural revitalization movements have provided a source of shelter and support for people seeking addiction recovery. When alcohol problems first rose within American Indian communities, a series of indigenous movements offered cultural pathways of recovery for individuals, families, and tribes. The earliest of these movements included the Handsome Lake Movement (1799), the Indian Prophet Movements (1805-1830s), the Indian Shaker Church (1882), and the Native American Church (1918), and this tradition continued in the contemporary period through the “Indianization of Alcoholics Anonymous,” the Red Road, and the Native American Wellbriety movement.⁵²

Outside Native America, people seeking recovery found peer-based support within the American Temperance movement’s network of temperance societies, temperance meetings, temperance hotels, and temperance libraries,⁵³ as well as within the larger religious awakening occurring in the United States in the eighteenth and early nineteenth centuries. The recovery-focused ministries within these larger religious movements were led by people in recovery. Recovery-focused ministries span the urban mission movement and religious

⁵¹ Benson, L. (1896). *Fifteen years in hell: An autobiography*. Indianapolis: Douglas & Carlon.

⁵² Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc.
Womak, M.L. (1996). *The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements*. Master’s thesis, Department of American Indian Studies, University of Arizona.

⁵³ Sigorney, L. & Smith, G. (1833). *The intemperate and the reformed*. Boston: Seth Bliss.

inebriate colonies of the late nineteenth century to the current growth of recovery ministries and recovery churches.⁵⁴

Recovery support initiatives were also spawned within the larger mid-twentieth-century civil rights; women's liberation; and lesbian, gay, bisexual, and transgender (LGBT) rights movements. The recovery ministry of the Reverend Cecil Williams and Glide Memorial Church in the Tenderloin District of San Francisco was a natural outgrowth of the civil rights movement and set a model for recovery ministries within disempowered communities.⁵⁵ Women for Sobriety, founded by Dr. Jean Kirkpatrick in 1975, was a product of the consciousness raising within the women's movement.⁵⁶ At the height of the youth counterculture movement of the 1960s, young people recovering from dependence on drugs other than alcohol and heroin felt little identification with the recovery cultures of AA or NA. They found service roles within indigenous service organizations, e.g., the Diggers (the service institution within the San Francisco youth counterculture), folk medicine institutions ("acid rescue"), crisis lines, "crash pads," and youth-focused counseling centers. Similarly, recovering people within the LGBT movement played key service roles within indigenous responses to the AIDS epidemic and championed LGBT recovery support meetings and LGBT-sensitive addiction treatment.

Abstinence-based religious and cultural revitalization movements have been strongest in historically disempowered communities of color in which alcohol and other drugs are deeply entwined with histories of enslavement and colonization.⁵⁷ Hope for personal recovery from addiction for members of a culturally besieged group is best couched in a larger framework of hope for a community and a people.⁵⁸

SECULAR RECOVERY MUTUAL-AID SOCIETIES

Secular recovery frameworks are distinctive in that they extol the power of personal (rational) will and mutual fellowship rather than God as the source of strength in overcoming alcohol and other drug problems. Prominent secular

⁵⁴ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51. Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco. Sanders, M. (2002). The response of African American communities to alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 20(3/4), 167-174.

⁵⁵ Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco.

⁵⁶ Kirkpatrick, J. (1978). *Turnabout: Help for a new life*. Garden City, NY: Doubleday and Company. Kirkpatrick, J. (1986). *Goodbye hangovers, Hello life*. NY: Ballantine Books.

⁵⁷ Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

⁵⁸ White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

recovery support societies in the United States have included the Washingtonians (1840), multiple fraternal temperance societies (1840s to 1890s), the Dashaway Association (1859), the Ribbon Reform Clubs (1870s), the Business Men's Moderation Society (1879), Women for Sobriety (1975), Secular Organization for Sobriety (1985), Rational Recovery (1986), Men for Sobriety (1988), SMART Recovery® (1994), Moderation Management (1994), and LifeRing Secular Recovery (1999).⁵⁹ Secular recovery groups have grown in number since 1975, but the availability of face-to-face meetings continues to be geographically limited. This limitation is balanced by the rapid growth in Internet-based secular recovery support meetings.

SPIRITUAL RECOVERY MUTUAL-AID SOCIETIES

Alcoholics Anonymous (AA) (1935) pioneered a spiritual, 12-Step program of recovery that has been widely adapted for other problems. Addiction recovery societies that have adapted AA's program include Narcotics Anonymous (1953), Pot Anonymous (1968), Pills Anonymous (1975), Chemical Dependent Anonymous (1980), Recoveries Anonymous (1981), Cocaine Anonymous (1982), Nicotine Anonymous (1985), Marijuana Anonymous (1989), Benzodiazepines Anonymous (1989), Crystal Meth Anonymous (1994), Prescription Drugs Anonymous (1998), and Heroin Anonymous (2004). Twelve-Step groups also exist for medication-assisted recovery (Methadone Anonymous, 1991; Advocates for the Integration of Recovery and Methadone, 1991; Mothers on Methadone, 2005). Twelve-Step groups are the most geographically dispersed and available recovery support meetings in the United States.

RELIGIOUS RECOVERY MUTUAL-AID SOCIETIES

Some recovery mutual-aid societies use deep religious experiences, religious ideas and rituals, and enmeshment in a faith community to initiate and sustain recovery and enhance the quality of personal/family life in recovery. Societies formed particularly for this purpose include the United Order of Ex-Boozers (1912); the Calix Society (1947); Alcoholics Victorious (1948); Alcoholics for Christ (1976); Overcomers Outreach (1985); Jewish Alcoholics, Chemically Dependent People and Significant Others (1979); Liontamers Anonymous (1980); Free N'One (1985); Celebrate Recovery (1990); Millati Islami (1989); and Victorious Ladies (ND). Celebrate Recovery is currently the fastest growing faith-based recovery support group in the United States, with groups in more than 10,000 churches.

⁵⁹ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2004). Addiction recovery mutual-aid groups: An enduring international phenomenon. *Addiction*, 99, 532-538.

FAMILY-FOCUSED RECOVERY SUPPORT SOCIETIES

Some recovery support societies support family members affected by alcohol and drug addiction. The most prominent of these societies have included the Martha Washington Society (1842), Alcoholics Anonymous Associates and AA Auxiliaries (1946-1950), Al-Anon (1951), Alateen (1957), Nar-Anon (1968), Families Anonymous (1971), Adult Children of Alcoholics (1978), Because I Love You (1982), National Association for Children of Alcoholics (1983), Co-Anon (1983), Codependents Anonymous (1986), and Recovering Couples Anonymous (1988). The most accessible family recovery support group in the U.S. is Al-Anon, with 14,924 groups in the U.S. and Canada.⁶⁰

OCCUPATION-BASED RECOVERY SUPPORT GROUPS

Recovery support societies (mostly 12-Step-associated groups) have formed for particular professional groups in recovery, including physicians (1949), lawyers (1975), women in religious orders (1979), psychologists (1980), social workers (1981), pharmacists (1983/1984), anesthetists (1984), nurses (1988), ministers (1988), and veterinarians (1990). These groups provide a very special form of peer support for people who face special challenges in recovery (e.g., ready access to drugs) and whose professional practice could be harmed by the stigma attached to addiction. They often operate in close association with formal professional assistance programs.

SHARED CHARACTERISTICS OF RECOVERY SUPPORT GROUPS

Much has been made of the differences between recovery support groups, but less attention has focused on what these groups share in common that distinguishes them from professionally directed addiction treatment. Such collective distinguishing characteristics include:

- origin and structure (spontaneous, self-governed movements);
- recovery context (recovery support is provided while living in one's own natural environment; there is no re-entry or concern about transfer of learning from institutional to natural settings);
- organizational context (mutual support provided through the medium of a community rather than through a professional/business organization);
- lack of hierarchy (purpose is to help one another with common problems—no one has claim to a morally superior position; no dichotomy between helper and helpee roles);
- support relationships guided by “group conscience” rather than codes of professional ethics or legal regulations;
- welcoming (emphasis on warm social fellowship);

⁶⁰ Al-Anon (2006). *Membership Survey Results, Al-Anon Family Groups, Fall 2006*. Retrieved August 30, 2006 from <http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf>.

- motivational enhancement via mutual encouragement and celebration of sobriety birthdays;
- practical antidotes to guilt (self-inventory, confession, acts of restitution, acts of service);
- pragmatism (focus on well tested strategies of daily living rather than theories about or extensive analysis of problem development);
- no intake, no diagnosis, no medical record;
- a strong service ethic through which members reach out to those still suffering from addiction;
- sustained availability of support during times of heightened vulnerability (e.g., evenings, nights, and weekends) when professionals are generally not available;
- support not contingent upon personal financial resources or the vagaries of public funding; and
- guidance provided via experience-based suggestions rather than rules or prescriptions.

RECOVERY SUPPORT FOR SPECIAL POPULATIONS

When individuals struggle to meet their needs within mainstream recovery support groups or when aspects of their experience are difficult to address within mainstream groups, recovering people have sought out others like themselves to share their “experience, strength, and hope” on these issues.

Gender-specific mutual-aid groups: Recovery support groups for women began within the Martha Washington societies of the 1840s, but, like most groups that would follow, these societies tried to integrate recovering women into support groups for wives and mothers of alcoholics. The first sustainable recovery support groups designed specifically for addicted women were started in the early 1940s within Alcoholics Anonymous. Female pioneers within AA began meeting together to share experiences and support on issues they could not raise in mixed-gender meetings. Twelve-Step meetings for women are now common in communities across the United States.

The second half of the twentieth century witnessed the development of alternatives to 12-Step groups for women, including Women for Sobriety, founded by Dr. Jean Kirkpatrick; Charlotte Kasl’s Sixteen Step Groups; and such faith-based recovery support groups as Women on the Move and Ladies Victorious.⁶¹ Men-only meetings also have risen within AA/NA, and Men for Sobriety was founded as an alternative recovery support group for men in 1988.

Beyond recovery support groups, gender-specific recovery support services grew out of efforts to craft an approach to addiction treatment based

⁶¹ Kasl, C. (1992). *Many roads, one journey*. New York: Harper Perennial. Kirkpatrick, J. (1978). *Turnabout: Help for a new life*. Garden City, NY: Doubleday and Company. Kirkpatrick, J. (1981). *A fresh start*. Dubuque: Kendall/Hunt Publishing. Kirkpatrick, J. (1986). *Goodbye hangovers, Hello life*. NY: Ballantine Books. Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco.

specifically on the needs of addicted women. Peer-based outreach services, mentoring programs, parenting education and coaching, trauma support groups, child care co-ops, and linkage to educational opportunities were included in these efforts.⁶² There have also been recent efforts to blend a recovery home for women and a women's community recovery center within the same program.⁶³

Age-specific recovery support: Special support for young people seeking recovery began in the mid-nineteenth century cadet branches of the Washingtonians, the Ribbon Reform Clubs, and the Keeley Leagues.⁶⁴ Young people's groups in AA began in the 1940s and led to the founding in 1958 of the International Conference of Young People in Alcoholics Anonymous—an annual event that now draws more than 3,000 young AA members from all over the United States. Alateen, which was founded in 1957, also serves as a source of support for adolescents who struggle with the alcoholism of a parent, as well as a pathway of entry into recovery for some of these young people who develop AOD problems.

Other peer recovery support frameworks that have meetings for youth—although with far fewer meetings than found in AA—include Narcotics Anonymous, Alcoholics Victorious, and Teen-Anon.⁶⁵ There is also a tradition of “old-timers” recovery support meetings in many communities. These meetings provide a forum to address later-stage recovery tasks and to address age-related issues that can pose a special challenge to late-stage recovery (e.g., loss of spouse, retirement, age-related health problems, physical disability, chronic pain, terminal illness).

Recovery mutual aid and advocacy in communities of color: As noted earlier, historical research has placed the beginnings of peer-based recovery support within mid-eighteenth century Native American tribes. Peer recovery support was provided within larger, abstinence-based cultural and religious revitalization movements and was followed by the cultural adaptation of culturally dominant support structures, e.g., the “Indianization of AA,” or the use of mainstream religious institutions for support for sobriety.⁶⁶ According to the

⁶² Iliff, B, Siatkowski, C., Waite-O'Brien, N., & White, W. (2007). The treatment of addicted women: Modern perspectives from the Betty Ford Center, Caron Treatment Centers and Hazelden. *Counselor*, 8(3), 42-48.

⁶³ Haberle, B. & White, W. (2007). *Gender-specific recovery support services: The evolution of the Women's Community Recovery Center*. Posted at http://www.facesandvoicesofrecovery.org/pdf/White/white_haberle_2007.pdf.

⁶⁴ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁶⁵ Passetti, L. & White, W. (2008). Recovery meetings for youths. *Journal of Groups in Addiction and Recovery*, 2, 97-121. Published simultaneously as: Passetti, L.L. & White, W.L. (2008). Recovery support meetings for youths: Considerations when referring young people to 12-Step and alternative groups. In J.D. Roth & A.J. Finch (Eds.), *Approaches to substance abuse and addiction in education communities: A guide to practices that support recovery in adolescents and young adults*. NY: Haworth Press.

⁶⁶ Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc. Womak, M.L. (1996). *The Indianization of Alcoholics Anonymous: An examination of*

research of Crowley,⁶⁷ Frederick Douglass was the most prominent of early African Americans in recovery. Douglass spoke openly of a period of intemperance in his life, signed a pledge of abstinence in 1845, maintained sobriety the rest of his life, and worked to promote Black temperance groups. Through his encouragement and example, nineteenth-century African Americans generated their own temperance and mutual-aid societies, e.g., the Black Templars. These societies and their pledges framed sobriety within the historical and cultural context of the post-Civil War years:

Being mercifully redeemed from human slavery, we do pledge ourselves never to be brought into slavery of the bottle, therefore we will not drink the drunkard's drink: whiskey, gin, beer, nor rum, nor anything that makes drunk come (Temperance Tract for Freedman).⁶⁸

People of color entered AA in the 1940s, and the first African-American AA group was established in Washington, DC in 1945. This was quickly followed by African American groups in St Louis, Valdosta (GA), and Harlem.⁶⁹ The history of recovery within Hispanic and Asian communities has yet to be documented. We will later review the scientific evidence related to the degree of participation of people of color in mainstream recovery support groups and report the affiliation rates and recovery outcomes of people of color within these groups.

Recovery support for and within the LGBT community: The first addiction recovery support group organized specifically for members of the lesbian, gay, bisexual, and transgender (LGBT) community was an AA meeting founded for gay men in Boston in 1949. Early LGBT AA meetings existed without being formally identified in AA meeting lists. The number of cities with gay AA groups grew from seven in 1975 to more than 300 in 1990.⁷⁰ Today, in cities like Chicago, there are more than 50 LGBT-focused AA meetings per week.

Recovery support for people with co-occurring disorders: People concurrently recovering from substance use and psychiatric disorders often find themselves marginalized from mental health support groups and mainstream addiction recovery support groups. Such marginalization led to the emergence of three specialty support groups: Dual Disorders Anonymous (1982), Dual Recovery Anonymous (1989), and Double Trouble in Recovery (1993). (See later discussion of research on these groups in Chapter Four.)

Native American recovery movements. Master's thesis, Department of American Indian Studies, University of Arizona.

⁶⁷ Crowley, J. (1997). Slaves to the bottle: Gough's autobiography and Douglass's narrative. In D. Reynolds & D. Rosenthal (Eds.), *The serpent in the cup: Temperance in American literature*. Amherst, MA: University of MA Press.

⁶⁸ Cheagle, R. (1969). *The colored temperance movement* (Unpublished thesis). Washington, DC: Howard University.

⁶⁹ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁷⁰ Borden, A. (2007). *The history of gay people in Alcoholics Anonymous from the beginning*. New York: Haworth Press.

Recovery support for people embedded within the criminal justice system: Recovery support groups have existed independent of, grown out of, or spawned inmate recovery counseling programs, e.g., the Addiction Recovery Counseling program at San Quentin Prison.⁷¹ Most of these programs were the fruit of volunteers from community-based recovery support groups (particularly AA and NA) carrying recovery messages to local jails and prisons. Winner's Circle, a recovery support program for ex-offenders, started in Connecticut in 1988 and was rebirthed and revamped in Texas in 1998. It has developed into a broader Winner's Community concept that involves Inner Circle (institution-based) and Winner's Circle (community-based) recovery support meetings to address the special obstacles offenders face in community re-integration and long-term recovery.⁷²

Recovery mutual aid in rural communities: People seeking recovery support in rural communities face many obstacles: 1) the absence or scarcity of mainstream recovery support meetings, 2) the absence of specialty meetings like those just described, and 3) problems meeting accessibility for those without driving privileges. These obstacles are being addressed, in part, through carpooling to access regional recovery support meetings, P-BRSS delivered face to face in people's homes, and P-BRSS services delivered via telephone (voice and text) and Internet.

Summary: Seen as a whole, specialty recovery support groups provide a:

- sanctuary of mutual identification and support for individuals estranged from mainstream community life,
- means of making sense of the recovery process through key developmental transitions,
- place of safety and shelter for high-status individuals in recovery whose careers or social standing could be injured by public disclosure of their addiction/recovery status,
- venue through which stigmatized populations can address their shared experience and unique obstacles to recovery, and
- forum to address recovery from addiction and co-occurring medical or psychiatric conditions.

If there is a contemporary story of recovery mutual aid, it is that of the growing varieties of recovery pathways and recovery experiences—all of which are cause for celebration. A regularly updated directory of this growing network of addiction recovery mutual-aid groups can be found at www.facesandvoicesofrecovery.org.

⁷¹ De Miranda, J. (2006). Recovery inside San Quentin Prison, training inmate counselors. *Alcoholism & Drug Abuse Weekly*, 18(39), 5-5.

⁷² The first national strategic planning meeting to expand the Winner's Community nationally was held in Hartford, CT in July 2008. Personal communication with Steven Shapiro.

GEOGRAPHICAL ACCESSIBILITY OF RECOVERY MUTUAL-AID GROUPS

Identification of the growing variety of recovery support groups leaves open the question of whether these options are really available to people in most communities in the United States. Table 4 illustrates the geographical availability of these groups. The founding date of each group is included so that the reader can estimate the rate of yearly growth of each recovery fellowship.

Table 4: Geographical Dispersion of Addiction Recovery Mutual-aid Groups in the United States⁷³

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Addictions Victorious	1986	45 meetings in 5 states (MD, NJ, NY, PA, and WA)
Addicts Victorious	1987	21 meetings in 5 states (IL-8, IO-1, MO-10, & TX-3)
Adult Children of Alcoholics	1978	1,500+ meetings
Al-Anon/Alateen	1951/1957	14,924 groups in the U.S. and Canada; all 50 states ⁷⁴
Alcoholics Anonymous	1935	More than 52,500 groups; all 50 states
Alcoholics for Christ		113 groups in U.S.; a particularly heavy concentration (43) in Detroit.
Alcoholics Victorious	1948	164 groups in U.S.
All Recoveries Anonymous	1981	50 chapters
Anesthetists in Recovery	1984	150+ members; provides phone support and linkage to support meetings
Benzodiazepines Anonymous	1989	Currently inactive
Benzo	1999	Online recovery support group for those withdrawing from benzodiazepines http://www.benzosupport.org/
Calix Society (adjunct to AA)	1947	27 affiliates in 18 states
Celebrate Recovery	1991	Faith-based peer recovery program in 10,000 churches across all 50 states
Chemically Dependent Anonymous	1980	65 groups

⁷³ Groups listed in this table were defined as currently inactive if multiple efforts to reach the group by listed phone and email failed to generate a direct response or information.

⁷⁴ Al-Anon (2006). *Membership Survey Results, Al-Anon Family Groups, Fall 2006*. Retrieved August 30, 2006 from <http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf>.

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Christians in Recovery	1992	All meetings held online
Cocaine Anonymous	1982	2,500 groups; most states
Co-Anon	1985	28 international groups
Co-Dependents Anonymous	1986	1,100 meetings worldwide
Crystal Meth Anonymous	1995	Meetings in all states
Double Trouble in Recovery	1989	250 groups
Dual Diagnosis Anonymous	1998	56 groups; 38 in CA
Dual Disorder Anonymous	1982	48 groups; most in Illinois
Dual Recovery Anonymous	1989	345 groups; 4 states (CA, OH, PA, MA)
Families Anonymous	1971	220 groups in 36 states
Free N'One	1985	55 groups
Heroin Anonymous	2004	35 meetings in Arizona, California, Illinois, Michigan, Texas, Utah, Washington
Intercongregational Addictions Program	1979	Support for recovering women in religious orders through phone, email, and conferences; membership of 710 plus in IL, Mass., Michigan, Alabama, California, New York, New Jersey, and Wisconsin
International Doctors in Alcoholics Anonymous	1949	175 groups; 6,000+ members
International Lawyers in Alcoholics Anonymous	1975	40+ groups; support through newsletter, conventions, and local meetings
International Ministers and Pastors in Recovery	1988	Support through phone network and international conference
International Nurses Anonymous	1988	Support through phone network, regional meetings, and international conference; INA provides those seeking help with names of recovering nurses in their area, who then do the linkage to support meetings
International Pharmacists Anonymous	1983/1984	Meetings held in tandem with summer schools and addiction conferences; annual regional meetings

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS)	1980	50 groups in 19 states; networking, community outreach, retreats, newsletter, literature, speakers bureau
LifeRing Secular Recovery	1999	73 groups in 15 states; 48 meetings in CA
Liontamers Anonymous	1980	No currently active meetings
Marijuana Anonymous	1989	200 groups; 24 states
Men for Sobriety	1988	5 affiliated groups, meetings primarily in Canadian Provinces
Methadone Anonymous	1991	400+ groups; 25 states
Millati Islami	1989	50 groups (12-Step adaptation based on Islamic principles drawn from the <i>Qu'ran</i> and <i>Hadith</i> , the sayings and practices of the Prophet Mohammad)
Moderation Management	1994	16 meetings; 12 states
Mothers on Methadone	2005	Online support available at http://www.methadoneanonymous.us/
Nar-Anon	1967	1,600 groups; 47 states; also sponsor Nar-Ateen and Nar-Atot meetings
Narcotics Anonymous	1953	More than 15,000 groups; 43,900 weekly meetings; 127 countries and all 50 states
Nicotine Anonymous	1985	450 groups; most states
Nurses in Recovery		Provide online message board for nurses in recovery
Overcomers in Christ	1987	100 churches, missions, and jail ministries registered
Overcomers Outreach	1985	700+ meetings in North America
Pagans in Recovery		All groups online
Pills Anonymous	1975	2 groups in New York City; also have San Francisco-based web support
Pot Anonymous	1968	Currently inactive; see Marijuana Anonymous
Prescription Drugs Anonymous	1998	Online support available at http://dailystrength.org/c/Prescription-Drug-Abuse/support-group

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Psychologists Helping Psychologists	1980	Support through newsletter and regional/national meetings
Rational Recovery	1986	There have been no RR group meetings since 1994; earlier groups now meet under auspices of SMART Recovery®.
Recoveries Anonymous	1981	50 Chapters
Recovering Couples Anonymous	1988	125 active meetings
Secular Organization for Sobriety	1986	480 groups; all 50 states
SMART Recovery®	1994	353 groups; 40 states
Social Workers Helping Social Workers	1981	Support through newsletter, email, and regional meetings; 300+ members
Teen-Anon	1999	Presently inactive
Veterinarians in Recovery	1990	Newsletter and online email support
Winner's Community	1988/1993	Local Winner's Circle groups now organizing into national Winner's Community network of recovering ex-offenders; local chapters with support meetings available in five states (IL, OH, IO, TX, KS)
Women for Sobriety	1975	200 groups in U.S.

Sources: Kelly & Yeterian (2008)⁷⁵ and direct group contact, with assistance from Jim Russell, Oklahoma Faces and Voices of Recovery; Groups are listed as currently inactive if web sites would not open or repeated calls to listed numbers went unanswered. Regularly updated information on these groups can be obtained from www.facesandvoicesofrecovery.org.

It can be seen from Table 4 that the accessibility of specific recovery support groups varies widely from state to state and community to community. P-BRSS specialists can play important roles in stimulating the development of recovery support alternatives in their local communities and in encouraging the use of online recovery support for people who do not have access to or are not comfortable in mainstream meetings.⁷⁶

⁷⁵ Kelly J. F. & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J. R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

⁷⁶ For a discussion of strategies to nurture the development of local recovery support groups, see: White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

Program Profile 1: Peer Group Facilitation Training (previously called “How to Start Your Own Self-help Group”)⁷⁷

Purpose: To enhance the abilities of peers in recovery to organize and facilitate recovery support groups and other recovery-related meetings (Started in 2007)

Service Elements: Two-day training design that includes 1) overview of Philadelphia behavioral health systems-transformation process, 2) methods of recovery support group development, 3) tips for meeting facilitation, 4) how to handle difficult situations.

Service Volume/Status: Since its inception, six trainings have been held, with more than 65 persons completing the training; a follow-up evaluation of the number of groups started by trainees as a result of the training is planned for 2009-2010.

Service Lessons: 1) An excellent gateway to other training and opportunities; 2) unanticipated benefit from personal network development via exchange of contact info between trainees; 3) Development of a learning community among training participants who have expertise in various aspects of group development and facilitation.

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INTERNET-BASED RECOVERY SUPPORT

Members of Alcoholics Anonymous began seeking out other AA members through USENET as early as 1983. Online AA communications increased throughout the 1980s and 1990s and now constitute a significant zone of growth in AA participation. Online recovery support groups sponsored by organizations other than AA began in the mid-1990s and have also grown exponentially. The Internet will be an increasingly important platform for recovery support in the future, and a day may arrive in the not-so-distant future when more people participate in online recovery support than in face-to-face meetings.

RECOVERY COMMUNITY SERVICE INSTITUTIONS AND ORGANIZATIONS

Communities of recovery have a long history of birthing service institutions to help people who needed more than could be provided within the framework of recovery support meetings. These service institutions date back to the founding of the first inebriate home in Boston (1857) and span a long line of support structures, including the rise of “AA homes and retreats,” information and referral centers, halfway houses, and early detoxification and treatment centers.

The recent growth of recovery community organizations (RCOs) marks a new development within the long history of recovery support. They are neither recovery mutual-aid societies nor professional treatment institutions. These new

⁷⁷ Personal communication with Ellen Faynberg, November, 2008.

organizations reflect the political and cultural awakening of recovering people and their families.⁷⁸

RCOs support a wide variety of new recovery support institutions: recovery community centers, recovery homes, recovery colonies, recovery schools, recovery industries, recovery ministries/churches, recovery cafes, recovery-based sports teams, recovery book clubs, recovery-themed radio and television programming, and recovery-themed art (from recovery music to recovery murals). Several of these emerging institutions are profiled in Chapter Five. These recovery community-building activities constitute one of the forces pushing addiction treatment programs to become “recovery-oriented systems of care” and to wrap traditional clinical services within a larger and more time-extended umbrella of P-BRSS.

Program Profile 2: PRO-ACT Philadelphia (Philadelphia, PA)⁷⁹
<i>Purpose:</i> “engage, activate, educate, and support” individuals and families in recovery; provide resources that help individuals/families initiate/sustain recovery and enhance their quality of life in long-term service.
<i>Service Elements:</i> 1) community education, 2) policy advocacy, 3) recovery support services, 4) recovery celebration/recreation, and 5) community service
<i>Service Volume/Status:</i> In all, 19,525 people were served in PRO-ACT activities this year.
<i>Service Lessons:</i> Importance of 1) broad representation across religious, spiritual and secular communities of recovery; 2) sustaining participatory processes; 3) sustaining focus on recovery community-building; 4) managing initial resistance through respect for critics, persistence, enduring service, and leading by example; 5) developing a collaborative relationship with professional treatment agencies and allied service agencies.
<i>For More Information:</i> Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

RECOVERY SOCIAL CLUBS

One of the most distinctive recovery community institutions is the recovery clubhouse. Recovery social clubs provide a haven of recovery fellowship and an outlet for sobriety-based leisure activities. The most notable of these clubs (many started by patients during their stay at treatment programs) have included the Ollapod Club (1868), the Drunkard’s Club (1871), the Godwin Association (1872), the Bi-Chloride of Gold Clubs (Keeley Leagues, 1891), the Jacoby Club (1910), and AA and other 12-Step Clubhouses (1940s-present). Until recently, recovery social clubs were restricted to 12-Step clubhouses; since

⁷⁸ Valentine, P., White, W., & Taylor, P. (2007). *The recovery community organization: Toward a definition*. Retrieved from

http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf.

⁷⁹ Personal communication with Bev Haberle, December, 2008.

early 2000, Recovery Community Centers that combine social club and recovery support service functions for people who embrace diverse recovery pathways are growing rapidly.

RECOVERY ADVOCACY ORGANIZATIONS

Individuals and family members in recovery have a rich modern history of founding recovery advocacy organizations. Particularly noteworthy is the work of the National Committee for Education on Alcoholism (1944)—the precursor to today’s National Council on Alcoholism and Drug Dependence (NCADD), founded by Mrs. Marty Mann, “the first lady of Alcoholics Anonymous.” Recovering people played key leadership roles through NCADD that contributed to the rise of mid-twentieth century addiction treatment. They also played key roles in creating new treatment modalities that would be replicated widely across the United States, e.g., the Minnesota Model of alcoholism treatment (1948-1950) and the birth of ex-addict-directed therapeutic communities (1958).

Recovery advocacy organizations have included the Addicts’ Rights Organization (1970, Philadelphia); the Committee of Concerned Methadone Patients and Friends, Inc. (1973, New York City); Association of Former Drug Abusers for Prevention and Treatment (ADAPT, New York, 1979); the Society of Americans for Recovery (SOAR), founded by former Senator Harold Hughes (1990); Advocates for the Integration of Recovery and Methadone (1991); National Alliance of Methadone Advocates (1988); local chapters of the National Council on Alcoholism and Drug Dependence that sought to recapture their public education and policy advocacy missions (late 1990s); and new grassroots recovery advocacy organizations (many of which received seed money from the Center for Substance Abuse Treatment’s Recovery Community Support Program, RCSP, 1998).⁸⁰

The Alliance Project grew out of the Johnson Institute’s Leadership Forum and set the stage for the 2001 Recovery Summit in St. Paul, Minnesota. At the Summit, Faces & Voices of Recovery was founded as a national infrastructure to launch a national educational and advocacy campaign. A directory of local recovery advocacy organizations can be found at www.facesandvoicesofrecovery.org. In 2003, the Center for Substance Abuse Treatment shifted the focus of its RCSP from recovery advocacy to peer-based recovery support services. (See later discussion.)

⁸⁰Woods, J.S. (1992). Advocacy and making change: The voice of the consumer. In: J.H. Lowinson, P. Ruiz, R.B. Millman, and J.G. Langrod (Eds.), *Substance Abuse: A Comprehensive Textbook* (2nd Edition). Baltimore, MD: Williams and Wilkins, pp. 865-873; While other countries have witnessed some political organizations of active drug users (e.g., the founding of the Swedish Users Union in 2002, see Palm, 2006), no such group has formed in the United States whose primary interest is advocacy on behalf of harm reduction, treatment, or recovery-related issues. Palm, J. (2006). The consumer, the weak, the sick, the innocent: Constructions of “the user” by the Swedish Users Union. In J. Anker, V. Asmussen, & D. Tops, (Eds.), *Drug users and spaces for legitimate action* (NAD Monograph no. 49, pp. 159-182). Helsinki, Finland: Nordic Alcohol and Drug Council.

Program Profile 3: Recovery Walk 2008 (Philadelphia, PA)⁸¹

Purpose: To conduct a highly visible recovery celebration event that honors individuals and families in recovery and provides recovery-focused education to the wider community; to build and mobilize “constituency of consequence” to advocate pro-recovery social policies and programs.

Service Elements: 1) Recovery program speakers and march through Fairmount Park, 2) advocacy tent with voter registration, 3) recovery education tent, 4) honoring of more than 100 recovery leaders with more than ten years of sobriety, 4) exhibits by treatment and recovery support organizations, 5) clothing handout, 6) barbeque and music following program and march.

Service Volume/Status: 4,500+ participants, including representatives from federal, state, and city government.

Outcomes: 1) Offering “living proof” of larger recovery community constituency exerts significant influence on participants, political leaders, and the larger community; 2) recovery celebration events are enormously validating and a vehicle for expunging internalized stigma/shame related to addiction. The event also allowed for increased networking among providers and a springboard to collaboration on additional advocacy efforts.

Lessons Learned: 1) Meticulous planning is the key to success of such major public events, 2) recovery celebration paraphernalia (e.g., t-shirts, hats, etc.) are important devices for recovery community building across pathways of recovery.

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RECOVERING PEOPLE WORKING IN NON-PROFESSIONAL SUPPORT ROLES IN ADDICTION TREATMENT

People in recovery worked as managers and aids in early inebriate homes, and in a variety of roles in urban missions and religion-oriented inebriate colonies in the mid-nineteenth century. Whether or not they should be included in medically oriented inebriate asylums and private addiction cure institutes was a subject of considerable debate and controversy. In spite of such controversies, recovering people continued to serve in non-professional roles in addiction treatment. Sobered alcoholics (and later ex-addict paraprofessionals) worked as attendants, techs, and aides in state psychiatric hospitals through the early-mid twentieth century and then made up nearly the entire workforce within the alcoholism halfway house movement of the 1950s and 1960s.⁸²

⁸¹ Personal communication with Bev Haberle, December 2008.

⁸² Blacker, E. & Kantor, D. (1960). Half-way houses for problem drinkers. *Federal Probation*, 24(2), 18-23. Rubington, E. (1967). The halfway house for the alcoholic. *Mental Hygiene*, 51, 552-560.

Recovering people then staffed a growing network of detox programs, residential treatment programs, and “social model” programs as volunteers, nursing aides, patient advocates, urinalysis monitors, clerical assistants, house managers, peer helpers, cooks, maintenance staff, drivers, outreach workers, and community educators.⁸³ Recovering men such as David M., Warren T., and Earl S. pioneered programs in business and industry to counsel alcoholic employees—precursors to the employee assistance counselor and modern peer assistance programs for physicians, nurses, and other professionals.⁸⁴

There is a rich history of recovering people serving as volunteers in addiction treatment to support people in recovery. This volunteer service work was often an extension of the service ethic within recovery mutual-aid programs and was delivered either within the framework of such programs (for example, Twelfth-Step calls, sponsorship, and other service work in AA) or through the framework of a volunteer program sponsored by an addiction treatment organization. AA volunteer work in hospitals began in the 1930s⁸⁵ and has continued to the present.

In 1970, the Lutheran General Hospital alcoholism treatment unit in suburban Chicago used more than 125 AA volunteers a month, including pairs of volunteers who were scheduled for all-night duty. Within a 30-day stay, patients were exposed to more than 60 recovering people from all walks of life.⁸⁶ A similar program utilizing more than 60 AA volunteers flourished in Cleveland’s Cuyahoga County Hospitals.⁸⁷ These volunteer programs were extolled for their positive effects on people undergoing treatment, and they often constituted the preparatory and recruiting grounds for addiction counselors.⁸⁸ As drug problems rose in communities during the 1960s and early 1970s, young recovering addicts

⁸³ Borkman, T. J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, 15(1), 7-17. Flores, V.J. & Rice, K.A. (1974). Training viewpoints on paraprofessional counselors. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1048-1050). Cambridge, MA: Schenkman. Talbott, J.A., Ross, A. M., Skerrett, A. F., Curry, M.D., Marcus, S.I., Theodorou, H., et al. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, 130, 805-808. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁸⁴ Fletcher, C. E. (2004). Experience with peer assistance for impaired nurses in Michigan. *Journal of Nursing Scholarship*, 36(1), 92-93. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁸⁵ Mann, M. (1946). Alcoholics Anonymous: A new partner for hospitals. *The Modern Hospital*, January, (reprint).

⁸⁶ McInerney, J. (1970). The use of Alcoholics Anonymous in a general hospital alcoholism treatment program. *Medical Ecology and Clinical Research*, 3(1), 22.

⁸⁷ Collins, G.B. & Barth, J. (1979). Using the resources of AA in treating alcoholics in a general hospital. *Hospital and Community Psychiatry*, 30(7), 480-482. Collins, G.B., Barth, J., & Zimec, G. (1980). Recruiting and retaining AA volunteers in a hospital alcoholism program. *Hospital and Community Psychiatry*, 32(2), 130-132.

⁸⁸ Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, 24(12), 839-841.

were also used as drug educators in the schools and as volunteers to “talk down” individuals entering hospitals with adverse drug reactions.⁸⁹

Volunteer programs linked to addiction treatment programs were extensive in the 1960s and 1970s.⁹⁰ Recovering volunteers were prized for their skill at engaging and encouraging clients, their ability to serve as recovery role models, and their guidance in reducing the cultural, racial/ethnic, and class barriers that existed between clients and professional staff. Thirty-five percent of drug abuse programs surveyed during this period had 50 or more volunteers, and half of all volunteers in this period reported a desire to work in addiction treatment due to a personal or family addiction/recovery experience, with 16% explicitly identifying themselves as ex-addicts.⁹¹ Former volunteers constituted 18% of all treatment staff and one-third of all non-degreed counselors in 1977.⁹² In the late 1970s, financial resources to support volunteer programs were provided to local treatment programs in more than 27 states through the National Institute of Alcohol Abuse and Alcoholism’s Volunteer Resource Development Program.

In spite of this support, the use of volunteers fell out of favor. This happened with the introduction of managed care and a shift in emphasis from inpatient to outpatient treatment in the 1980s and 1990s. At the same time, there was a move toward greater professionalization, regulation, and commercialization of addiction treatment that unfolded throughout the 1980s and 1990s.

In the 1960s and 1970s, volunteers were viewed as a panacea because they could address staff shortages. However, there were criticisms and concerns related to the time and costs involved in sustaining a volunteer program, the limited functions volunteers could perform, and problems related to reliability and poor management of relationship boundaries with clients.⁹³ In the transition to a professional addiction treatment workforce, recovering alcoholics and addicts often were employed or volunteered to serve as “patient instructors” of

⁸⁹ Termansen, P.E. (1973). Hospital program uses nonmedical volunteers to talk down drug users. *Hospital and Community Psychiatry*, 24(6), 384. Kline, J.A. & Wilson, W.M. (1972). Ex-addicts in drug abuse prevention education. *Drug Forum*, 1(4), 357-366. .

⁹⁰ The use of volunteer programs did vary by modality; one study found that 41% of therapeutic communities and 48% of other drug-free programs used volunteers, but that only 9% of methadone maintenance programs had volunteer programs. Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

⁹¹ Aiken, L., LoSciuto, L., & Ausetts, M. (1981). *A study of volunteers in drug abuse programs* (DHHS Publication No. (ADM) 81-1147). Rockville, MD: National Institute on Drug Abuse.

⁹² Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

⁹³ Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

physicians, nurses, and other traditional helping professionals.⁹⁴ Ironically, services that were provided by recovering volunteers in the early history of addiction treatment, e.g., serving as a “personal aid” to clients, “socializing with clients,” and helping educate professionals about recovery, are now being revived in the “new” push for P-BRSS.

Soon we will address the role of the addiction counselor—a role that moved from a “paraprofessional” to professional status between 1965 and 1985—but it is noteworthy that many recovering people continued in non-clinical support roles throughout the modern history of addiction treatment. The formal advocacy for expanded recovery support roles in the growth of P-BRSS constitutes a long-overdue recognition of the importance of these roles and a refocusing on the function of non-clinical recovery support. The P-BRSS initiative is also leading to a revitalization or rebirth of recovery volunteer activities through alumni associations, recovery advisory councils, consumer councils, and formal volunteer programs.

RECOVERING PEOPLE WORKING IN PROFESSIONAL ROLES IN ADDICTION TREATMENT

Recovering physicians were among the earliest recovering people to fill professional roles in addiction treatment institutions. The Keeley Institutes, the largest of the nineteenth-century addiction cure institute franchises, hired more than 130 recovering physicians—most Keeley graduates—to administer their Bi-Chloride of Gold Cure.⁹⁵ Dr. T.D. Crothers, representing the mainstream inebriate asylums, strenuously rejected this practice, as evidenced by the following excerpt from his 1897 editorial in *The Journal of Inebriety*:

It is confidently asserted that a personal experience as an inebriate gives a special knowledge and fitness for the study and treatment of this malady. While a large number of inebriates who have been restored engage in the work of curing others suffering from the same trouble, no one ever succeeds for any length of time or attains any eminence....Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic deficits of the higher mentality....The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the

⁹⁴ Klein, R.F., Foucek, S.M., & Hunter, S.D. (1991). Recovering alcoholics as patient instructors in medical education. *Substance Abuse*, 12(2), 82-89. Spickard, A., Johnson, N. P., & Burger, C. (1989). Learning through experience. *Alcohol Health and Research World*, 13(1), 36-39.

⁹⁵ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2000c). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases*, 19(2), 1-10.

*work any length of time...Every reformed man as a rule will relapse, particularly if he follows the business of curing others.*⁹⁶

A “lay therapy” movement began in the early twentieth century through the work of a clinic, established by the Emmanuel Church in Boston, that combined religion, psychology, and medicine in the treatment of nervous and mental disorders. The clinic quickly developed a specialty in the treatment of alcoholism and used trained recovering alcoholics as lay psychotherapists. Noted lay alcoholism therapists such as Courtenay Baylor, Francis Chambers, and Richard Peabody pioneered this role.⁹⁷ Lay therapists worked within newly formed outpatient alcoholism clinics of the 1940s, and recovering AA members—Pat. C., Lynn C., Otto Z., Lon J., Fred E., and Mel B.—defined the first formal Counselor on Alcoholism positions within the emerging “Minnesota Model” at Pioneer House, Hazelden, and Willmar State Hospital. AA members who were physicians, nurses, and psychologists also began to fill service roles in newly opening alcoholism units in hospitals.⁹⁸ Recovering alcoholics also pioneered non-AA-oriented treatment and recovery philosophies during the mid-twentieth century.⁹⁹

Recovering alcoholics and addicts were recruited heavily to fill helping roles in the new treatment programs of the 1960s. They filled roles in programs funded under federal anti-poverty, mental health, traffic safety, and industrial alcoholism initiatives, as well as within alcoholism clinics funded by state alcoholism authorities. The popularization of the recovering paraprofessional “alcoholism counselor” and the “ex-addict counselor” occurred in tandem with interest in the potential of paraprofessionals in other fields, such as education, law, mental health, public health, and criminal justice.¹⁰⁰ The mix of professionals and paraprofessionals in the alcoholism field of the 1960s triggered intense debate over the question, “Who is qualified to treat the alcoholic?”¹⁰¹—a debate we will discuss in depth shortly.

⁹⁶ Crothers, T.D. (1897). Reformed men as asylum managers. *Quarterly Journal of Inebriety*, 19, 79-81, Quote from pages 79-80.

⁹⁷ Baylor, C. (1919). *Remaking a man*. NY: Moffat, Yard & Company. Peabody, R. (1936). *The common sense of drinking*. Boston: Little, Brown, and Company. Strecker E. A. & Chambers, F. T., Jr. (1938). *Alcohol: One man's meat*. New York: The MacMillan Company.

⁹⁸ Anonymous (1952). I'm a nurse in an alcoholic ward. *Saturday Evening Post*, October 18, pp. 40-41, 111-116. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁹⁹ McGoldrick, E. (1966). *The conquest of alcohol*. NY: Delacorte Press.

¹⁰⁰ Cressey, D.R. (1965). Social psychological foundations for using criminal in the rehabilitation of criminals. *Journal of Research in Crime and Delinquency*, 2(2), 49-59. Durham, E.L. (1974). St. Leonard's House: A model in the use of ex-offenders in the administration of correction. *Crime & Delinquency*, 20(3), 269-280. Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher.

¹⁰¹ Krystal, H. & Moore, R. (1963). Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol*, 24, 705-720.

The use of people in recovery in paid or volunteer roles was not always initiated out of the best intentions. Jim McInerney explains:

*There are treatment programs that give lip service only to the prudence of employing AA member-alcoholism counselors. Prior to the days of greater enlightenment this was an appeasement tactic used to keep the AA community happy: this was true particularly in cases where the AA community happened to be a major source of referrals for the facility in question.*¹⁰²

The use of recovering alcoholics and ex-addicts in new addiction treatment programs began as a necessity (given the lack of trained professionals willing to work in these settings), but rapidly became a fad.

*It now appears that the ex-addict or "indigenous leader" has become vogue. The demands for ex-addicts to participate in treatment programs are becoming so numerous that the extent of an ex-addict's training and self-help experience is being overlooked. The demand is not for skilled, qualified manpower, but for the label "ex-addict." Thus anyone who once stuck a needle in his arm is coming to be regarded as possessing curative powers, or magic. The only requirement he must fill is that he no longer uses drugs.*¹⁰³

Ex-addicts of varying levels of commitment and competence filled service roles in newly created drug abuse programs. Rhodes and White describe the earliest efforts in Illinois to bring ex-addicts into helping roles in the 1960s.

*Each day, after the closing of the clinic, about 75% of the staff remained in the area to cop drugs from the addicts in treatment...With the exception of "Moses," there was total disrespect for the ex-addict staff. The street reputation of the majority of the staff carried over into the clinic and was not conducive to making positive changes in the client's lifestyle...[It was quite some time before] the role model concept was widely accepted and there was a core group of ex-addicts who were abstinent and "really taking care of business."*¹⁰⁴

Rhodes and White go on to describe the closed world of the ex-addict counselor during these early days.

¹⁰² McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield, IL: Charles C. Thomas Publisher, Quote from page 95.

¹⁰³ Deitch, D. & Casriel, D. (1967). The role of the ex-addict in the treatment of addiction. *Federal Probation*, 31, 45-47.

¹⁰⁴ Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman, quote from pages 1052, 1054.

...we have created a new society composed totally of ex-addicts....Our whole lives have become treatment oriented. Instead of re-entering the "normal" society, we have created an "ex-drug abuser" society. In fact, we have found that ex-addicts are still not accepted by society. This is recognized in our attempts to secure jobs, utilize facilities such as community recreational institutions and even some hospitals still look down on the ex-addict. This has caused ex-addicts to look to each other for social support, thus creating this sub-culture...ex-addicts are, in fact, an untouchable caste to most segments of society, whether abstinent or not.¹⁰⁵

As federal funds were channeled through states and local communities in the early 1970s, there was tremendous pressure to professionalize the roles of "alcoholism counselor" and "drug abuse counselor" via credentialing, certification, and licensure.¹⁰⁶ This triggered new addiction studies programs in colleges, universities, and private training institutes. Also noteworthy were efforts to organize the growing legion of recovered alcoholic and ex-addict counselors through professional counselor associations—most notably the National Addiction Services Guild (1971) and the National Association of Alcoholism Counselors and Trainers (1972).¹⁰⁷

New funding for addiction treatment services also brought an influx of professionals into the emerging alcoholism field and drug abuse field. This created competition and conflict that split along multiple lines: recovered versus non-recovered, non-degreed versus degreed, black and brown versus white, non-privileged versus privileged.¹⁰⁸ Some recovering people in the field felt that ex-addicts were being colonized.

¹⁰⁵ Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman, quote from pages 1057, 1060.

¹⁰⁶ Banken, J.A. & McGovern, T.F. (1992). Alcoholism and drug abuse counseling: State of the art considerations. *Alcoholism Treatment Quarterly*, 9, 29-53. Keller, D. S. & Dermatis, H. (1999). Current status of professional training in the addictions. *Substance Abuse*, 20, 123-140.

¹⁰⁷ In contrast to other countries, there have been few efforts in the United States to organize active drug users or clients in treatment as a political force; in contrast, see Palm, J. (2006). The consumer, the weak, the sick, the innocent: Constructions of "the user" by the Swedish Users Union. In J. Anker, V. Asmussen, & D. Tops (Eds.), *Drug users and spaces for legitimate action* (NAD Monograph no. 49, pp. 159-182). Helsinki, Finland: Nordic Alcohol and Drug Council.

¹⁰⁸ Deitch, D.A. (1974). The end of the beginning: Dilemmas of the paraprofessional in current drug abuse treatment. In E. Senay & H. Alksne (Eds.), *Developments in the field of drug abuse: Proceedings of the national drug abuse conference* (pp. 1029-1036). Cambridge, MA: Schenkman.

*...the ex-addict "paraprofessionals" are in an insecure position, limited in mobility, and living within a sophisticated but exploitative relationship with professional staff.*¹⁰⁹

Some professionals entering the field during the early 1970s were very critical of paraprofessional staff. A 1972 article penned by a psychologist and physician suggested that ex-addicts were characterologically unsuited for the work of counseling; were prone to subjectivity, rigidity, and over-identification with the drug culture; and were simply trading dependency on drugs for lifelong dependency on a treatment institution.¹¹⁰ They concluded:

*It is our suggestion that the failure of current programs may be due, in part, to the misuse of ex-addict counselors as drug treatment personnel.*¹¹¹

The titles "paraprofessional" and "subprofessional" conveyed some of the disdain with which recovering counselors were regarded.¹¹² The few career ladders that existed for early paraprofessionals in recovery suggested that their ultimate value would come only by abandoning their experiential roots and seeking further academic education and professional training.

Rivalries and conflicts within treatment programs increased as people with such varied backgrounds sought to find their niche.¹¹³ Chappel, Charnett, and Norris suggested three factors that contributed to poor teamwork between paraprofessional ex-addicts and professionals: 1) the implied stigma in such professional labels as paraprofessional, ex-addict, recovered drug user, and non-degreed counselor; 2) struggles over status, power, and money; and 3) differences in philosophy and approaches to counseling.¹¹⁴ Intra-program conflicts were often rooted in stereotypes, feelings of inadequacy, and the emotional stress inherent in addiction counseling among both groups of workers. They were also rooted in objective conditions visible to anyone working within

¹⁰⁹ Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman.

¹¹⁰ Zimmerman, R. S. & Coughlan, A. J. (1972). The (mis)use of ex-addicts in drug abuse treatment programs. *Drug Forum*, 1(4), 367-372. Suchotliff, L. & Seligman, E. (1974). The myth of the ex-addict staff. *Drug Forum*, 4(1), 47-51.

¹¹¹ Zimmerman, R. S. & Coughlan, A. J. (1972). The (mis)use of ex-addicts in drug abuse treatment programs. *Drug Forum*, 1(4), 367-372.

¹¹² Gusfield, J. (1982). Deviance in the welfare state: The alcoholism profession and the entitlements of stigma. *Research in Social Problems and Public Policy*, 2, 1-20. Staub, G. & Kent, L. (1973). Thoughts to ourselves. In G. E. Staub & L. M. Kent. (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas.

¹¹³ Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, 24(12), 839-841.

¹¹⁴ Chappel, J.N., Charnett, C.V., & Norris, T.L. (1974). Paraprofessional and professional teamwork in the treatment of drug dependence. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 297-306). Cambridge, MA: Schenkman.

these environments: ex-addicts performed the same duties as professionals but worked longer hours and received far less than the wages professionals were paid. The issue of disproportionate pay for people in recovery has pervaded the modern history of addiction treatment and continues today.¹¹⁵

In 1974, David Deitch, an early pioneer within the therapeutic community movement, reflected on the state of the treatment field and the future of the ex-addict counselor.

*There is no question that we are at the end of the beginning. Nor is there a question that, without adequate training, many of those who participated in making the beginning, will fade away in the end.*¹¹⁶

As the 1970s gave way to the 1980s, pressure built for recovering people working as addiction counselors to become certified, which in many states meant pursuing a college education. Studies from the early 1970s found that 70% of ex-addict counselors did not have a high school diploma or GED.¹¹⁷ As Deitch predicted, many among the first generation of recovering counselors did not make the transition to a professionalized field of addiction counseling. As that transition progressed, terms like “paraprofessional” became less tenable and were dropped from the field’s lexicon.¹¹⁸ However, people in recovery without college degrees did continue to be hired as outreach workers, case managers, peer educators, recovery coaches, and research assistants in the addictions field and in addiction-related projects sponsored by mental health and child welfare agencies, AIDS service organizations, and religious organizations (1980s-present).

The percentage of American addiction counselors with recovery experience and the range of peer recovery support services in addiction treatment declined in recent decades. (See later discussion.) This decline occurred in tandem with the professionalization of the field and with a fee-for-service system that no longer paid for community education, outreach, crisis intervention, case coordination meetings, home visits to families, vocational/employment counseling, aftercare, or volunteer recruitment and training. This trend may be reversing itself due to growing interest in peer

¹¹⁵ Olmstead, T. (2007). Why are recovering counselors paid less? *Substance Abuse*, 28(1), 31-44. Olmstead, T.A., Johanson, J.A., Roman, P.M., & Sindelar, J.L. (2005). What are the correlates of substance abuse counselor salaries? *Journal of Substance Abuse Treatment*, 29, 181-189.

¹¹⁶ Deitch, D.A. (1974). The end of the beginning: Dilemmas of the paraprofessional in current drug abuse treatment. In E. Senay & H. Alksne (Eds.), *Developments in the field of drug abuse: Proceedings of the national drug abuse conference* (pp. 1029-1036). Cambridge, MA: Schenkman.

¹¹⁷ Bokos, P. J. (1974). Education and training for drug abuse paraprofessional staff. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1037-1040). Cambridge, MA: Schenkman.

¹¹⁸ Rosenberg, C. (1982). The paraprofessional in alcoholism treatment. In E. Pattison & E. Kaufman, (Eds.), *Encyclopedic Handbook of Alcoholism* (pp.802-809). New York: Gardner Press.

recovery support programs. The recovery coach role, in particular, is spreading within addiction treatment and through special addiction-related service projects in allied fields (public health, public welfare, child welfare, and criminal justice). The use of recovering people within faith-based recovery ministries has also grown in tandem with new federal funding for faith-based recovery support services through the Access to Recovery (ATR) program. (See later discussion.)

All the recovery support roles filled by recovering people rested on a belief that recovery brought a depth of “experience, strength, and hope” that could be mobilized to help others seeking recovery. That people in recovery could offer a special level of empathy and respect is a foundational concept in the history of P-BRSS. (We will review the scientific status of that proposition later in this monograph.)

*The drunkard is now regarded in a new light by the Washingtonians. Instead of being considered a cruel monster—a loathsome brute—an object of ridicule, contempt and indignation, as formerly, we are now taught to look upon him as a brother...as a slave to appetite, and debased by passion—yet still as a man, our own brother.*¹¹⁹

*For the reformed inebriate knows each avenue to his brother's heart; he highly touches the string on which hangs all his sorrow; no rebuke mingles with his invitation of welcome...*¹²⁰

It is important to understand how the role of addiction counselor changed through efforts to professionalize this role. The “paraprofessional” era that spanned temperance missionaries, early twentieth-century lay therapists, and the paraprofessional counselors of the mid-twentieth century had many distinguishing elements that dissipated over the past three decades through the professionalization of the addiction counselor role.

Table 5 illustrates this author's views on some of the key transitions that distinguish the “paraprofessional” counseling (services provided primarily by people in recovery) era from era of professionalized addiction counseling (services provided primarily by degreed professionals—including recovering people who pursued advanced education and training). Like the differences and vulnerabilities laid out in Table 1, the paraprofessional and professional paradigms represent opposite ends of a continuum, with actual characteristics and practices in both eras existing along that continuum. (For further discussion of real and perceived differences between recovering and non-recovering addiction treatment staff, see Chapter 6, “Scientific Evaluation of Peer-based Services.”)

¹¹⁹ A Member of the Society. (1842). *The foundation, progress and principles of the Washingtonian Temperance Society of Baltimore, and the influence it has had on the temperance movements in the United States*. Baltimore: John D. Toy.

¹²⁰ Crowley, J. (1999). *Drunkard's progress: Narratives of addiction, despair and recovery*. Baltimore: Johns Hopkins University Press.

Table 5: Paradigms of “Paraprofessional” and Professional Addiction Counseling

Dimension	Paraprofessional Counseling Era	Professional Counseling Era
Primary Credential	Length and quality of personal sobriety (active program of recovery maintenance); history of service work in recovery community; passion for working with alcoholics/addicts; apprenticeship under recovery elders.	Pre-service college education, training, certification, and past professional experience; learning via professional training and professional supervision.
Foundational Knowledge	Experience-based knowledge of recovery and recovery community; knowledge of the individual/family highly valued.	Theory- and science-based knowledge of addiction; written treatment protocols; emphasis on adherence to evidence-based practices; knowledge about addiction and execution of clinical techniques.
Role Definition	Role ambiguously defined; generalist: performed variety of tasks and worked with all clients; clear expectation to be a recovery role model.	Core counselor functions defined; frequent role specialization by level of care, modality, activity, and client populations.
Skill Emphasis	Client engagement; focus on verbal communication and encouragement.	Client engagement; focus on conceptual (e.g., diagnosis, treatment planning) and writing skills.
Diagnosis	Emphasis on self-diagnosis by the client, or on diagnosis based on the paraprofessional’s own experience.	Emphasis on knowledge of DSM diagnoses and patient placement criteria.
Status of Service Recipient	Member of organizational family and/or recovery community—a “friend,” “brother,” “sister.” ¹²¹	A “patient” or “client.”
Degree of Power Differential	Minimal power differential; stance of staff toward most clinically deteriorated client: “There but for the Grace of God go I.”	Great power differential between counselor and client; professional counselor seen as expert.
Style of Helping Interaction	Informal, open, and spontaneous.	More formal, personally guarded, and strategic.

¹²¹ Some peer-based programs are attempting to break down the distance that has grown between the helper and helpee in addiction treatment: See the description of the “Friend’s Connector” program in Klein, A., Canaan, R., & Whitecraft, J. (1998). Significance of peer social support for dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, 8, 529-551.

Dimension	Paraprofessional Counseling Era	Professional Counseling Era
Teaching Style	Ranged from discussion Model (truth lies in the exploration of collective experience) to personal narrative (truth based in part on the helper's experience).	Didactic Model: Truth lies in the conveyance of scientific findings to clients by professional authorities through one-on-one persuasion, lectures, videos, and assigned readings.
Counselor Self-disclosure	Accessible and vulnerable; self-disclosure and storytelling an essential part of the art of counseling. ¹²²	Hidden and protected; self-disclosure discouraged as unprofessional and a potential breach of ethics.
Companionship	Perceived as a critical need in recovery and a legitimate form of recovery support provided by the counselor.	Companionship between counselor and client perceived as a breach of professional ethics.
Length of Service Relationship	Measured in months/years.	Measured in days/sessions.
Focus of Counseling Work	Focus on character and context: Helping client get out of self—connecting with pro-recovery resources and relationships beyond the self; focus on doing (accountability for working an active recovery program).	Focus on the “clinical”: helping the client get into self—exploring painful developmental issues thought to cause addiction or impede the recovery process; greater focus on feeling (expiation of pain) and thinking (insight).
Ethical Guidelines	Folklore; group conscience; ethical landmines hidden; ethical breaches common.	Ethical codes clearly defined; heightened level of ethical sensitivity; preoccupation with management of appropriate boundaries in service relationships.
Service Documentation	Non-existent to minimal; nearly all time spent interacting with clients; emphasis on counselor's communication and relationship skills.	Burdensome and ever-increasing; decreasing amounts of time available to interact with clients; great emphasis on writing/recording skills.

It can be seen that many of the core characteristics of the helping relationship in addiction treatment changed through counselor professionalization and the broader evolution of addiction treatment as a cultural institution. The point is not to label these changes in categories of “good” or “bad” but to note

¹²² Recovering addiction counselors perceive a much higher benefit to the client of counselor self-disclosure than do addiction counselors who are not in recovery. Mondlick, L.E. (1998). Certified substance abuse counselors' perceptions of the effects of self-disclosure of their recovery status on the therapeutic relationship with substance abuse clients. Dissertation, New York University. *Dissertation Abstracts International*, 59(05B), 2156.

historically that many aspects of the “paraprofessional” era are now being revived through P-BRSS specialty roles.

CURRENT RECOVERY COACHING PRACTICES IN THE PUBLIC AND PRIVATE SECTORS

Recovery coaching—experience-based guidance through the transition from recovery initiation to recovery maintenance—is offered through four different organizational venues: 1) self-supported or publicly-funded recovery community organizations, 2) publicly funded addiction treatment programs or allied service organizations, 3) private addiction treatment programs, and 4) private organizations that once specialized in conducting pre-treatment interventions on a fee basis and are now expanding their services to include post-treatment monitoring and support.

Examples of recovery community organizations (RCOs) providing recovery coaching services include three organizations whose early funding came from the Center for Substance Abuse Treatment’s Recovery Community Support Program. The El Paso Recovery Alliance is currently contracted with the state of Texas to conduct six months of recovery coaching for clients discharged from residential addiction treatment at a rate of \$25 per recovery coaching session.¹²³

The Association of Persons Affected by Addiction in Dallas, Texas is contracted through Value Options to provide group-based and individual recovery coaching for eight weeks following discharge from addiction treatment. Coaching services may be re-authorized for an additional eight weeks. The cost is \$15 per 15-minute unit of individual recovery coaching and \$27 per person per hour for group recovery coaching.¹²⁴

The Connecticut Community of Addiction Recovery (CCAR) is contracted by the State of Connecticut to provide telephone-based recovery coaching to 2,500 individuals for 12 weeks following their discharge from addiction treatment. They are contracted at a rate of \$108 per person for this service.¹²⁵ Many RCOs extend recovery coaching services far beyond the period for which they are being paid. For example, CCAR has been providing recovery coaching to some people for more than 150 weeks—far beyond the 12 weeks for which they are contracted. RCOs are using a mix of paid staffing models and volunteer models of providing recovery coaching services. These efforts in the public sector are triggering calls for regulations governing recovery coaching and the certification of recovery coaches.

¹²³ Personal communication with Ben Bass, September, 2008.

¹²⁴ Personal communication with Joe Powell, September, 2008.

¹²⁵ Personal communication with Phil Valentine, September 2008

Program Profile 4: Telephone Recovery Support (Hartford, CT)
Connecticut Community of Addiction Recovery

Purpose: 1) to call a person in recovery once a week to “check in” and help the person maintain recovery, 2) to intervene early to re-stabilize recovery following lapse/relapse episodes.

Service Elements: After signing a consent form provided by either a treatment provider or a sober house, or at a local recovery community center, the person is called once a week for at least 12 weeks by a trained volunteer, who provides recovery coaching. The calls are made from local recovery community centers. Telephone support started out in Connecticut in 2005, with volunteers from CCAR’s Willimantic Recovery Community Center calling 22 persons in recovery to offer support. Today, telephone support is being provided to 371 individuals on a weekly basis from all four Recovery Community Centers.

Survey Outcomes: 1) During the lifetime of the program (2005-present), volunteers have placed more than 36,131 calls to 1,803 unduplicated “recoverees.” 2) Of those calls, volunteers were able to make contact 12,129 times (33.6% of the time). 3) Of those reached, 96.4% reported that they had used other supports for their recovery, and 96.7% reported being “in recovery.” 3) 2.6% of those contacted reported having relapsed, and, of those, 59.4% were able to be helped back into recovery.

Service Lessons: 1) Volunteers report that they get more out of making the calls than do those receiving the calls. 2) Volunteers do not have to be in recovery to make the calls. The fact that the call comes from someone who cares about how the recovery process is going is enough to make it helpful. 3) A simple program can generate phenomenal results.

For More Information: Contact Kevin Hauschulz at kevin@ccar.us or 860-218-9531

Telephone-based recovery services hold great promise for individuals and families as an independent service or as an adjunct to addiction treatment. Given the growth of a youth-based “text culture,” it is surprising that there are so few reports of text messaging being investigated as a medium of recovery support service delivery for adolescents.

In the public sector, programs are offering a range of recovery coaching services that include pre-treatment outreach, in-treatment case management, and post-treatment monitoring and support.¹²⁶

¹²⁶ Ryan, J. P., Marsh, J. C., Testa, M. F., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services. *Social Work Research*, 30(2), 95-107. Loveland, D. & Boyle, M. (2005). *Manual for recovery coaching and personal recovery plan development*. Retrieved August 18, 2008 from <http://www.bhrm.org/guidelines/RC%20Manual%20DASA%20edition%207-22-05.doc>.

Program Profile 5: New Pathways Project (Philadelphia, PA)¹²⁷

(Assertive Street and Community Outreach)

Purpose: Reaching the unreachable—those whose pain is so deep and so profound, and whose lives are so chaotic, that triggering hope for recovery takes assertive and sustained involvement; reducing the risk of HIV infection/ transmission among minority men and women by facilitating access to addiction treatment and supportive social services.

Service Elements: Street outreach in areas of high drug activity and outreach in key institutions (including housing shelters, church-based meal programs, community corrections facilities, halfway houses and recovery homes, health fairs, advocacy groups) provided by staff and peer volunteers (Pathfinders); case management; pre-treatment counseling to enhance treatment readiness; pre- and post-treatment educational/support group meetings; Consumer Advisory Council.

Service Volume/Status: 15,000+ outreach/educational contacts; focused case management and pre-treatment counseling with 200+ adult men and women per year.

Service Outcomes: Preliminary outcomes for 128 clients reveal reduction in binge drinking in past 30 days from 53% to 19%; reduction in drug use in past 30 days from 100% to 37%; 44% of clients entered treatment—40% of these for first time; HIV testing in prior six months rose from 32% to 70%; HIV+ clients receiving medical care for HIV rose from 44% to 100%.

Service Lessons: People who would not otherwise seek addiction treatment can be engaged through assertive outreach, case management, and recovery coaching. People can recover under the most extreme and adverse conditions.

For More Information: Contact Eugenia Argires (eargires@phmc.org)

Recovery coaching in the private addiction treatment sector is typified by two well known treatment institutions.

Since 1996, the Betty Ford Center has provided a post-treatment, telephone-based Focused Continuing Care (FCC) program to treatment graduates. The FCC program entails meeting with the recovery coach during primary treatment, being oriented to FCC, signing a contract for participation in FCC, and participating twice a month in monitoring/support calls for the first three months and one call per month for up to one year.¹²⁸

Hazelden has launched MORE (My Ongoing Recovery Experience)—a continuing care service that includes educational materials, workshops and retreats, a personal recovery coach who provides monitoring and support for the

¹²⁷ Philadelphia Health Management Corporation (2008). New Pathways Project: A community-based model for building recovery capital. Unpublished manuscript. Bond, L. & Argires, E. (2008). *New Pathways Project*. Power-point Presentation.

¹²⁸ Cacciola, J. S., Camilleri, A. C., Carise, D., Rikoon, S. H., McKay, J. R., McLellan, A. T., et al. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford Center Focused Continuing Care protocol. *Addictive Behaviors*, 33, 1208-1216.

first three months after treatment, and web-based recovery education and recovery check-ups. Like the Betty Ford Center, Hazelden's enhanced continuing care services are provided to all patients completing primary treatment, and the cost for these continuing care sessions is usually built into the basic charge for inpatient services.¹²⁹

The most cursory search of the Internet reveals an array of private, fee-based recovery coaching services. The early impetus of these services came from private practitioners who began offering "back-end" monitoring, case management, and recovery coaching to supplement their "front-end" intervention services. Most began this extension of services as part of professional assistance programs for pilots, physicians, nurses, pharmacists, and attorneys and then extended these monitoring and support services to clients not in such professional roles. Some of the more prominent of those offering private recovery coaching include Intervention 911; Intervention 180; Southworth and Associates; and Recovery Support Services, LCC. There is even an association of recovery coaches—Recovery Coaches International, founded in 2005.

Private recovery coaches—also referred to as sober coaches, sober mentors, recovery companions, personal recovery assistants, and sober escorts—offer a wide menu of recovery support services, including:

- sober escort/transport to and from a treatment center;
- in-home meetings;
- live-in recovery support;
- telephone- or Internet-based recovery coaching;
- oversight of drug testing;
- linkage to recovery support meetings (arranging sponsorship, transportation to meetings, co-attendance at meetings, facilitation of virtual recovery groups, facilitation of daily readings, and step work);
- sober companionship;
- meetings with families; and
- guidance on daily journaling, leisure activities, and daily nutrition.

Private recovery coaches generally offer bundled service packages that reflect different levels of monitoring and support intensity. These can range from weekly progress reports on recovery activities faxed to the coach, with monitoring and follow-up if no fax is received, to more enhanced packages involving regular visits or calls to review the client's status, supervision of random urine screens, meetings with family members and co-workers, active referral to needed resources, ongoing case management, and extended time periods for monitoring. These packages can range from \$1,000-\$6,000 per year for basic services and up to \$10,000 per year for enhanced monitoring options (plus the cost of drug testing) and such ancillary service roles as those of sober escort to and from treatment or live-in recovery coach. It is common for private services to split the monitoring and active recovery coaching functions between different contractors.

¹²⁹ Duda, M. (2005). Hazelden to launch unique continuing care program. *The Voice*, Summer.

The extent to which private fee-for-service recovery coaching constitutes P-BRSS is open to question, as it is unclear the percentage of recovery coaches who are in personal recovery and who use a peer-based versus professional philosophy to guide service delivery. Surveys comparing private sector and public sector addiction treatment programs note that staff members in the private sector have higher levels of education, but recovery representation has not been reported in these studies.¹³⁰ Recovery coaching, like addiction counseling before it, is being promoted as a “new profession,” with recovery coach training and certification programs advertised at fees exceeding \$3,000.¹³¹

The ideal length of monitoring and support advocated by recovery coaches whom the author has interviewed is usually identified as five years. This is based on the length of the early professional monitoring model, but nearly everyone interviewed reported average lengths of monitoring of less than one year—a function of limited time periods of reimbursement for monitoring services by third-party payors and difficulty sustaining clients through the monitoring and support process.

In the next chapter, we will discuss the key theories and principles that guide the design and delivery of P-BRSS.

¹³⁰ Rodgers, J. H. & Barnett, P. G. (2000). Two separate tracks: A national multivariate analysis of differences between public and private substance abuse treatment programs. *American Journal of Drug and Alcohol Abuse*, 26(3), 429-442.

¹³¹ Crossroads Coaching advertised Recovery Coaching Certification Program of six modules offered at a fee of \$3,100.

Chapter Three

The Theoretical Foundations of Peer-Based Recovery Support

SUMMARY OF KEY POINTS

- Some people who survive a life-altering disorder or experience develop special sensitivities, insights, and skills to help others similarly afflicted.
- The zeal recovering people bring to helping others reflects a deep sense of purpose and destiny, as well as a means of making amends for past addiction-related harm to others.
- Addiction counseling and peer recovery support rest on two overlapping, but potentially conflicting, traditions of authority: professional knowledge, and experiential knowledge.
- The course and outcome of chronic illnesses are profoundly influenced by the peer support available to individuals and families who experience such illnesses.
- Exposure to the personal stories and lives of people in recovery can serve as a catalyst of personal transformation for people suffering from severe AOD problems.
- Peer recovery support helps to remedy the inequality of power/authority, perceived invasiveness, role passivity, cost, inconvenience, and social stigma associated with professional help for severe AOD problems.
- Peer helping is reciprocally beneficial: the helper and helpee both draw value from helping exchanges.
- In historically oppressed communities, hope for individuals and families is best framed within a broader vision of hope for a people, e.g., attaining social justice; addressing disparities in health, stigma, and discrimination; and widening doorways of community participation and contribution for all people.
- Understanding the ecology of recovery is key to the design of effective P-BRSS in all communities.
- P-BRSS provide experience-grounded guidance in the journey from cultures of addiction to cultures of recovery.
- As peer-based recovery support movements develop, they face twin risks: 1) anti-professionalism, “incestuous closure,” and implosion; and 2) loss of mission via the forces of professionalization, bureaucratization, and commercialization.
- All peer-based recovery support services rest on the primacy of personal recovery.

- P-BRSS constitute a mechanism of long-term recovery support that can enhance recovery outcomes at costs far less than those of services provided through sustained professional care.

A number of academic disciplines have set forth theories about the active ingredients of mutual peer support. Magura and colleagues' review of these theories is outlined in Table 6.

Table 6: Academic Theories on Mutual Peer Assistance

Theoretical Framework	Proposed Active Ingredient of Mutual Helping	Psychological/Social Process	Proponent
Social Psychology	Commitment to Change	Helping others strengthens one's own commitment to change and anchors key ideas and activities that support change.	Reissman, 1965 ¹³²
Group Psychotherapy	Altruism	Helping others serves as a personal antidote to self-absorption.	Yalom, 1985 ¹³³
Social Learning Theory	Enactive Attainment	Helping others spurs personal change by enhancing the self-efficacy and self-esteem of the helper.	Bandura, 1995 ¹³⁴
Cognitive Consistency Theory	Resolution of Ambivalence	Helping others forces resolution of one's own ambivalence about changing.	Petri, 1996 ¹³⁵
Self Psychology	Alteration of Personal Identity	Helping others strengthens one's own identity as a changed person.	Kaplan, 1996 ¹³⁶

P-BRS does not begin with theory-building and scientific testing. It emerges from the collective experience of communities of recovering people. There are, however, certain ideas and principles that one consistently hears from those delivering and receiving P-BRS. The purpose of this chapter is to summarize briefly the core ideas upon which peer recovery support services have been and are being constructed. The question of the extent to which these

¹³² Riessman, F. (1965). The "helper" therapy principle. *Social Work*, April, pp. 27-32.

¹³³ Yalom, I. (1985). *The theory and practice of group psychotherapy* (3rd edition). New York: Basic Books.

¹³⁴ Bandura, A. (1995). *Self-efficacy: The exercise of control*. New York: Freeman.

¹³⁵ Petri, H.L. (1996). *Motivation* (4th edition). Pacific Grove, CA: Brooks/Cole.

¹³⁶ Kaplan, H.B. (1996). *Psychosocial stress*. New York: Academic Press.

propositions are supported by scientific studies will be addressed in chapters four through seven.

“NOTHING ABOUT US WITHOUT US”

The essence of empowerment is the ability of people to participate in decisions that affect their lives and to join together with others in similar circumstances to advocate on issues of common concern. Peer recovery support is an expression of such empowerment. P-BRS rests on the proposition that recovering people have a right to be involved in and serve in leadership positions in the planning, design, delivery, and evaluation of addiction treatment and recovery support services. P-BRS is a testimony that recovering people can be part of the solution to AOD problems at personal, family, community and cultural levels.

Program Profile 6: Recovery Advisory Committee (RAC, Philadelphia, PA)¹³⁷
<i>Purpose:</i> To provide a vehicle through which recovering individuals and their families can provide input into recovery-focused behavioral health systems-transformation efforts in the City of Philadelphia. (Established May, 2005)
<i>Service Elements:</i> 1) RAC member recruitment; 2) Regular RAC meetings; 3) RAC policy statement and recommendations.
<i>Service Outcomes:</i> 1) Development of recovery definition and core recovery values; 2) refinement of recovery vision to guide behavioral health systems transformation; 3) input into system-change priorities; 4) planning peer leadership development initiatives; 5) currently evaluating outcomes of RAC's first three years of operation.
<i>Service Lessons:</i> 1) Importance of broad representation of communities of recovery; 2) importance of balance between individuals and family members in recovery; 3) importance of authenticity of recovery representation, e.g., representatives who are not also professional stakeholders in the system; 4) value of preparing recovery representatives in ways of participating with professionals; and 5) value of outside facilitation to ensure active and full participation by everyone.
<i>For More Information:</i> Contact Joan King at jking@netreach.net or 215- 721-7409

¹³⁷ Personal communication with Joan King, November, 2008.

Program Profile 7: Recovery Foundations Training (Philadelphia, PA)¹³⁸

Purpose: To increase participants' understanding of recovery from behavioral health disorders. The training is available to staff of the Department of Behavioral Health/Mental Retardation Services, persons in recovery, family members, community-based service providers, and members of the larger community.

Service Elements: A 2-day training program that provides: 1) an overview of recovery principles, 2) key elements of recovery oriented care, and 3) application of recovery concept to each participant's service/support role.

Service Volume/Status: As of November, 2008, 64 Recovery Foundations Training sessions have been conducted for more than 1,600 participants.

Service Outcomes: 1) Provided concrete examples of what individual/family recovery looks like and how it can be supported, 2) enhanced relationship building between individuals/families in recovery and multiple service providers, 3) forged a common language related to recovery and recovery support services, 4) created a recovery-focused learning community, and 5) affirmed hope for long-term recovery.

Service Lessons: 1) 2-day format was an obstacle to participation for some constituencies; alternative formats could be utilized; 2) wonderful vehicle for relationship building and mutual learning between professional and recovery communities.

For More Information: Contact Michelle Khan Michelle.Khan@phila.gov or at 215-685-4768.

Program Profile 8: Peer Leadership Academy (PLA, Philadelphia, PA)¹³⁹

Purpose: To train individuals and family members in recovery to assume leadership roles in Philadelphia's recovery-focused systems-transformation process

Service Elements: The 26-week training program contains such modules as Listening in Leadership, Identity and Diversity, Negotiating Paradigms and Terms, The Win/Win Strategy, Building Relationships, Resolving Conflicts, The Interpersonal Dimension of Leadership, Analyzing Current Reality; Mental Models Toward Current Reality, Systems Thinking, Strengths Theory and Team Building, Shared Vision, Team Learning, etc.

Service Volume/Status: Effort spans recovery from addiction, mental illness and co-occurring disorders; 60 recovering people have been trained by four faculty members; college credits are provided for completion of training.

¹³⁸ Personal communication with Michelle Khan, November, 2008

¹³⁹ Personal communication with Bev Haberle, December, 2008

Peer Leadership Academy (Continued)

Service Outcomes: Survey of graduates revealed a total of 740 hours of voluntary community service in past nine months—a 40% increase over pre-training levels; graduates reported a total of 40 community presentations made since completion of training.

Service Lessons: 1) Increase in volunteer hours seems to be related to increased self-confidence of graduates; 2) PLA has provided a pool of effective volunteers to serve on key recovery advisory committees in Philadelphia; 3) quality of committee participation has increased in tandem with volunteers' skills, confidence, and assertiveness; 4) having volunteers intern with committees provides great preparation for full membership on committees; 5) positive feelings of graduates toward the PLA is now the primary recruitment vehicle for new recruits.

For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

Program Profile 9: A New Day: A Celebration of Recovery (Philadelphia, PA)

Purpose: Conduct a one-day conference planned, organized, delivered, and evaluated by people in recovery for people in recovery; celebrate the growing role of the peer recovery culture in the transformation of Philadelphia's behavioral health care system.

Service Elements: 1) 16 focus groups held throughout the city to determine desired conference agenda; 2) people in recovery serving as facilitators and presenters; 3) national keynote speakers (John Lucas and Vince Papale); 4) ten concurrent workshops on such topics as wellness, advocacy, housing opportunities, storytelling, family support, leadership training, and cultural competency; 5) formal lunch; 6) Recovery Champion awards to individuals and community-based organizations; 7) recovery talent show/exhibit (arts, crafts, music, dance); and 8) a recovery celebration dance.

Service Volume/Status: 1,000 participants, with many turned away due to space limitations.

Service Outcomes: 1) Wonderful means of celebrating and elevating importance of peer culture in systems-transformation processes; 2) followed up with Valuing the Village Conference held in November, 2008, focusing on health disparities.

Service Lessons: Following were critical to conference success: 1) stakeholder inclusiveness in planning group, 2) focus groups to generate interest and focus of conference content, 3) recovery volunteers who helped manage the event.

For More Information: Contact Jennifer Dorwart at JDorwart@pmhcc.org or 267-825-6861

THE WOUNDED HEALER TRADITION

People who have survived a life-altering disorder or experience may develop special sensitivities, insights, and skills to help others in similar circumstances.

*The term [wounded healer] refers to a person whose personal experience of illness and/or trauma has left lingering effects on him—in the form of lessons learned that later served him in ministering to other sufferers, or in the form of symptoms or characteristics that usefully influenced his therapeutic endeavors.*¹⁴⁰

The idea and value of the “wounded healer” has deep roots in religion, from beliefs that the shaman’s healing powers emanate from his or her own emotional/spiritual death and rebirth to the Christian view of Jesus as the “suffering servant.” The wounded healer tradition is also embedded within the history of medicine and psychiatry. Sigmund Freud and Carl Jung suggested that the psychotherapist must deeply understand his or her own wounds to heal others effectively.¹⁴¹ The source of healing for wounded healers is not based on what they have been taught, but on who they are as people and the resources they can draw from within themselves and their communities.¹⁴²

But in the context of P-BRSS, must these inner resources include recovery from addiction? In his history of Alcoholics Anonymous, historian Ernest Kurtz noted the many non-alcoholics who had played important roles in the history of AA—Dr. Silkworth, Sister Ignatia, Sam Shoemaker, Willard Richardson, Frank Amos, Dr. Harry Tiebout, and Father Ed Dowling, to name only a few. Here is how Kurtz described these individuals.

*They were not alcoholic, but they did all have something in common: each, in his or her own way, had experienced tragedy in their lives. They had all known kenosis; they had been emptied out; they had hit bottom....whatever vocabulary you want. They had stared into the abyss. They had lived through a dark night of the soul. Each had encountered and survived tragedy.*¹⁴³

The “kinship of common suffering” can transcend such labels as “alcoholic” and “non-alcoholic.” The most important dimensions of the peer relationship are emotional authenticity, humility, and the capacity to offer support from a position of moral equality. One’s addiction/recovery career may be of secondary value, and, as we shall see, does not in itself ensure such traits.

In communities undergoing recovery-focused transformation of their behavioral health care systems, the increased interaction between people in recovery and traditional professionals without a history of addiction results in an inevitable diminishment of the social space between the two groups. These interactions inevitably produce a sense that “we are all in recovery.” It remains to be seen whether this marks a pathway of empathy and community inclusion—an important element in the destigmatization of addiction and recovery—or a dilution

¹⁴⁰ Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine*, 75, 1-36.

¹⁴¹ Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine*, 75, 1-36.

¹⁴² Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

¹⁴³ Kurtz, E. (1996). Spirituality and recovery: The historical journey. *The Blue Book*, 47, 5-29.

of the meaning of recovery that might weaken the essence of peer recovery support, its future as a social movement, and its role in behavioral health care.

THE POWER OF CALLING (AMENDS IN ACTION)

The zeal to help others that recovering people feel reflects a deep sense of personal purpose and a means of making amends (restitution and reparations) for past addiction-related harm to others. The courtship with death that accompanies severe alcohol and other drug dependency often generates survival guilt in early recovery and a tendency to question why one's life was spared when it so easily might have been lost. One common answer to this question is that one was spared to bring a message of hope to others who are still suffering, or that one has an important role to play in preventing others from following the same path. Such sense of destiny has propelled service work within recovery fellowships and through the roles of recovery coach and addiction counselors, and has inspired recovering people to bring their existing occupational roles or gifts to the service of the recovery cause.

I can sympathize with and appreciate the condition of the poor inebriate. Have I not been one of their number? I now have an object in life to reform men. (Thomas Doutney, Nineteenth-Century Temperance Lecturer)¹⁴⁴

After a month of daily increasing happiness, I was struck with an overwhelming sense of gratitude....I felt I must do something in return. When I learned about the A.A. ward at Knickerbocker [hospital] I knew what that something would have to be....I can't convey how much it means to see the transformation in people....To know that I had some small part in this rebirth is a blessing far beyond what I deserve. (Teddy R., a recovering nurse in AA, describes her motivation for seeking work in one of the earliest hospital-based alcoholism units in New York City.)¹⁴⁵

Zemore¹⁴⁶ aptly describes such service work as a “behavioral manifestation of a spiritual orientation.”

The calling in recovery to help others can also serve as a form of restitution and reparation for past injuries to others.

Now I can give back to the people and cities I helped poison. (Gerard Wallace, peer educator in Oakland, CA)¹⁴⁷

¹⁴⁴ Doutney, T. (1903). *Thomas Doutney: His life, struggle and triumph*. Battle Creek, MI: The Gage Printing Company, Limited.

¹⁴⁵ Anonymous (1952). I'm a nurse in an alcoholic ward. *Saturday Evening Post*, October 18, pp. 40-41, 111-116.

¹⁴⁶ Zemore, S.E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, 100(4), 447-450.

Program Profile 10: Amends in Action (Philadelphia, PA)¹⁴⁸
Purpose: Reduce addiction-related social stigma by putting a positive face on recovery; increase public visibility of people in long-term recovery; provide a venue for restitution and community service by people in recovery.
Service Elements: 1) Food bank volunteer crews, 2) Habitat for Humanity volunteer crews, 3) nursing home visitation/activities, 4) community clean-up, 5) Suitcases for Recovery (for foster children), and 6) Philadelphia's Big Give (gifts for people in early recovery, e.g., diapers for the children of mothers in recovery).
Service Volume/Status: 120 people have participated in eight Amends activities during the 2008 calendar year.
Service Outcomes: 1) Increased self-esteem from acts of restitution and giving, 2) increased ownership of one's own recovery, 3) increased integration of people in recovery with the larger community—less estrangement and alienation.
Service Lessons: 1) Service ideas must come from volunteers, 2) service activities must be well planned, 3) service processes must provide opportunities for mutual support and fellowship among volunteers.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

A consequence of this sense of calling that pervades peer-based services is an ambivalence or outright distrust of accepting money for such support. Each recovery mutual-aid fellowship and each recovering person accepting a paid position to provide recovery support has had to work out his or her own philosophy on this issue. The results have included a preference for volunteerism or an emphasis on the importance of distinguishing between what one does as voluntary “service work” (“giving back”) and what one provides as a paid service.¹⁴⁹

EXPERIENTIAL KNOWLEDGE

Addiction counseling and P-BRSS rest on two overlapping but potentially conflicting traditions of authority: professional knowledge and experiential knowledge.¹⁵⁰ The former is knowledge acquired from outside of self—

¹⁴⁷ Galindo, L., Maginnis, T., Wallace, G., Hansen, A., & Sylvestre, D. (2007). Education by peers is the key to success. *International Journal of Drug Policy*, 18(5), 411-416.

¹⁴⁸ Personal communication with Bev Haberle, December, 2008.

¹⁴⁹ A.A. Guidelines for A.A. Members Employed in the Alcoholism Field. (ND). New York: General Service Office, Alcoholics Anonymous.

¹⁵⁰ Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456. Brown, B.S. (1993). Observations on the recent history of drug user counseling. *The International Journal of the Addictions*, 28(12), 1243-

information passed from master to apprentice through traditions of observing, testing, and thinking about a phenomenon. The latter is knowledge from inside—wisdom acquired by directly experiencing a phenomenon. Experiential knowledge is pragmatic—“concrete, specific, and commonsensical”—as opposed to theoretical or scientific.¹⁵¹

The experiential knowledge upon which P-BRS rests is wisdom drawn from one’s lived experience of recovery and the knowledge acquired by living in a community of shared recovery experience—a way of knowing quite different from the knowledge gained through research and reasoning.

They [drunkards] fully understand each other’s language, thoughts, feelings, sorrows, signs, grips, and passwords, therefore yield to the influence of their reformed brethren much sooner than to the theorists who speak in order that they may receive applause. (D. Banks McKenzie, Founder of the Appleton Temporary Home)¹⁵²

This difference in worldview is so significant that people in recovery have long used special terms to designate those who have not had addiction/recovery experiences (*earthlings, civilians, normies*). At its extreme, the value of experiential knowledge over professional knowledge (knowledge gained through observation, scientific study, and rational analysis) can be so strongly extolled as to suggest that *only* those who have experienced addiction and recovery can effectively counsel the addicted. The following, drawn from an addiction counseling trade journal, typifies this view:

But there can be no middle ground. The primary care giver in the alcoholism treatment center has to know what he/she is talking about and that means they have to have lived through the misery they hope to somehow spare for others. They cannot understand what their patients have gone through if they have not gone through that very same thing.¹⁵³

The counter position, typified in the 1963 Kystal-Moore debate, “Who is qualified to treat the alcoholic?” states that only those with advanced professional education are qualified to treat those suffering from addiction.

Of the disciplines now working with alcoholics only some psychiatrists, social workers and psychologists seem to satisfy the criteria of adequate preparation for treating the emotional problems at hand....The former problem drinker, however, who controls his drinking on the basis of his

1255. Kurtz, L.F. (1984). Ideological differences between professionals and A.A. members. *Alcoholism Treatment Quarterly*, 1(2), 73-85.

¹⁵¹ Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456.

¹⁵² McKenzie, D. (1875). *The Appleton Temporary Home: A record of work*. Boston: T.R. Marvin & Sons.

¹⁵³ Gallagher, D. (1990). The case in favor of recovering counselors. *C.D. Professional*, 8(1), 21.

*A.A. activities, but who has not discovered and effectively worked through his own emotional problems is in a worse position to function as an individual therapist to the alcoholic than a person without a history of alcoholism in the past but with no experience.*¹⁵⁴

Polarized debates between these ways of knowing arise periodically in the addictions field. However, neither having successfully overcome an addiction nor having earned an academic degree ensures one's ability to help others achieve and sustain recovery from addiction. (See studies reviewed in chapter six.) Each offers a different foundation upon which recovery assistance can be extended.

Where professionals extol the superiority of particular conceptual frameworks or particular methods of treatment, recovery advocates have emphasized that the attitude and relationship in which help is offered is more important than theory or technique.¹⁵⁵ Where these two worlds meet is in the agreement that there are essential traits and relational qualities that transcend knowledge, skills, competence, and access to needed resources, and that enhance service outcomes with those addicted to alcohol and other drugs. These include:

- interest/caring,
- warmth/rapport/trust,
- genuineness/sincerity,
- empathy/understanding,
- tolerance/acceptance,
- caring/non-possessiveness,
- perceptiveness/sensitivity,
- honesty/candor,
- firmness/fairness/flexibility, and
- immediacy/concreteness/common sense.¹⁵⁶

These traits and dimensions appear to be common to all helping relationships.¹⁵⁷ P-BRSS are founded on the premise that the nature of the

¹⁵⁴ Krystal, H. & Moore, R. (1963). Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol*, 24, 705-720.

¹⁵⁵ Mann, M. (1973). Attitude: Key to successful treatment. In G. E. Staub & L. M. Kent (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas. McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield: IL: Charles C. Thomas Publisher.

¹⁵⁶ Ottenberg, D. (1977). Traditional and nontraditional credentials in addictive problems: A dispatch from the battlefield. *The Addiction Therapist*, 2(1), 56-63. Lemere, F., Williams, R., Scott, E., Bell, R, Falkey, D., & Myerson, D. (1964). Who is qualified to treat the alcoholic? Comments on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol*, 25, 558-572. Wolf, S. (1983). Criteria for effectiveness: Recovered professionals as counselors. *Focus on Alcohol and Drug Issues*, 6(3), 22, 28.

¹⁵⁷ Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology*, 2, 95-103. Truax, C. B. (1963). Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction.

helper and the helping relationship are more important than the source of authority upon which the helper draws. The traits and abilities of natural helpers are not contingent upon training and education, although such experiences can enhance or erode such natural assets.¹⁵⁸

Different ways of knowing may match the learning styles of different people and may be of benefit to the same individuals/families at different stages of long-term recovery. This stands as a counter-argument to those who say these ways of knowing are incompatible, as suggested below.

*It is our thesis that the future of alcoholology will have to be established along either craft lines, exemplified by the paraprofessional alcoholism counselor, or scientific lines, embodied by the professional scientist. Because the defining properties and operational principles required for membership in a craft are different from those of a science, a détente would be difficult to achieve. The point is not that either approach is superior, but that marriage of the two prevents growth and progress. The synergism that is created acts in a negative rather than complementary way.*¹⁵⁹

As traditional professionals entered the addictions treatment field in large numbers in the 1970s, they alleged that reliance on experiential knowledge was restraining the maturation of the field and blamed this state of affairs on the influence of AA.

*Clinical treatment is not the logical outgrowth of scientific discoveries but instead remains an encapsulated body of theories and shopworn slogans that are apparently immune to the outcome of scientific research. Personal investment and the lack of openness to new findings and fresh conceptualizations are the hallmarks of the typical alcoholism treatment setting.*¹⁶⁰

*Alcoholics Anonymous' continued domination of the alcoholism treatment field has fettered innovation, precluded early intervention, and tied us to a treatment strategy, which, in addition to reaching only a small portion of problem drinkers, is limited in its applicability to the universe of alcoholics.*¹⁶¹

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- Journal of Counseling Psychology*, 10, 256-263. Carkhuff, R. & Truax, C. (1965). Lay mental health counseling: The effects of lay group counseling. *Journal of Counseling Psychology*, 29, 426-431.
- ¹⁵⁸ Wolf, S. (1974/1975). Counseling—for better or for worse. *Alcohol Health and Research World*, Winter, 27-29.
- ¹⁵⁹ Kalb, M. & Proper, M.S. (1976). The future of alcoholology: Craft or science. *American Journal of Psychiatry*, 133(6), 641-45.
- ¹⁶⁰ Kalb, M. & Proper, M.S. (1976). The future of alcoholology: Craft or science. *American Journal of Psychiatry*, 133(6), 641-45.
- ¹⁶¹ Tournier, R. E. (1979). Alcoholics Anonymous as treatment and as ideology. *Journal of Studies on Alcohol*, 40, 230-239. For articles countering the contention that core ideas from AA have retarded progress by claiming a singular view of alcoholics and an exclusive

Critics of peer recovery support suggest that peer helpers lack objectivity and that relying on one's experiential history may inhibit the ability to understand individual needs and differences. Advocates of P-BRSS respond that the potential for experiential bias is no different from the personal and ideological biases that professionals bring to the helping process, and that the peer's lack of theoretical bias is an advantage.

*...the paraprofessional's lack of investment in a particular theoretical framework or diagnostic rubric allows him to be open to undistorted observation and to be free from the need to place an interpretation on behavior or thought. Further, his lack of theoretical bias allows him to think of the patient as a total person and to plan for his needs beyond psychotherapy.*¹⁶²

The key tenets of P-BRSS include the following: 1) any form of bias can undermine the helping relationship, 2) bias is innately human and unavoidable, and 3) bias can be recognized and actively managed via self-knowledge and competent supervision, to minimize its potential harm to those receiving P-BRSS. Trading personal bias for theoretical bias via the professionalization of P-BRSS is not an advancement that will widen the doorways of entrance into recovery.

CHRONIC ILLNESS AND PEER SUPPORT

The course and outcome of chronic illnesses are profoundly influenced by the peer support available to individuals and families experiencing the prolonged effects of such illnesses. Addiction has long been characterized as a chronic illness,¹⁶³ and recent research confirms that the course and outcome of severe AOD problems closely resemble those of Type 2 diabetes mellitus, hypertension, and asthma.¹⁶⁴ However, addiction has been treated through two models that, until recently, have lacked a focus on long-term recovery support. The first is an acute-care model of intervention focused on brief biopsychosocial stabilization followed by termination of the service relationship. This model is typified by brief outpatient or inpatient/residential treatment programs. The

pathway of recovery, see: Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, 20 (3/4), 5-40. Miller, W. & Kurtz, E. (1994). Models of alcoholism used in treatment: contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, 55(2), 159-166.

¹⁶² Talbott, J. A., Ross, A. M., Skerrett, A. F., Curry, M. D., Marcus, S. I., Theodorou, H., et al. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, 130, 805-808.

¹⁶³ White, W. L. & McLellan, A. T. (2008). Addiction as a chronic disorder: Key messages for clients, families and referral sources. *Counselor*, 9, 24-33.

¹⁶⁴ McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695.

second is a palliative care model whose primary focus has been on reduction of harm to society. This model does not usually include sustained peer recovery support services or assertive linkage to communities of recovery. This approach is typified by methadone treatment programs that offer few ancillary services.¹⁶⁵

Evaluations of these acute-care and palliative-care models reveal significant problems in attraction and retention; inadequate scope, duration, and intensity of services; weak linkages to communities of recovery; and poor continuing care participation rates. People completing addiction treatment are precariously balanced between recovery and re-addiction in the weeks and months following discharge, and current models of intervention are plagued by high post-treatment relapse and re-admission rates.¹⁶⁶

Recovery is not fully stable and durable (the point at which the risk of future lifetime relapse drops below 15%) until after 4-5 years of continuous sobriety.¹⁶⁷ Assertive linkage to communities of recovery and post-treatment continuing care that include regular recovery check-ups (monitoring, support, and, when needed, re-intervention) enhance long-term recovery outcomes¹⁶⁸ but are not routinely provided to those completing addiction treatment. All of these findings support experimentation with pre-treatment, in-treatment, and post-treatment peer recovery support services.

Chronic disorders are difficult to experience and to treat because of their complex etiology, prolonged course, unpredictable ebb and flow of symptoms, lack of a definitive cure, substantial changes in lifestyle required for effective management, and progressive drain of personal and family emotional resources. Dr. Max Weisman made this point in the early 1970s in defense of including recovering peers in the treatment of alcoholism.

There is a whole group of chronic illnesses where changes in patient's life style, attitudes and behavior are critically necessary for effective recovery and rehabilitation to take place....Diseases like diabetes, emphysema and tuberculosis, cardiac pathologies, arthritis and numerous others, for

¹⁶⁵ White, W. & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, 9(3), 24-33.

¹⁶⁶ Scott, C. K., Foss, M. A., & Dennis, M.L. (2005b). Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, 28(Supplement 1), S63-S72. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

¹⁶⁷ White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

¹⁶⁸ Scott, C. K., Dennis, M. L., & Foss, M. A. (2005a). Recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, 78, 325-338. McKay, J. R. (2005a). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100(11), 1594-1610. White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

*some considerable time have had their para-professionals....Alcoholism has been a late-comer.*¹⁶⁹

A premise for the management of all chronic illnesses, and for P-BRSS in particular, is the importance of continuity of support over an extended period of time. Addiction treatment in the United States is often referred to as a “system” of care, but, in reality, there is no system. Reimbursement based on discrete service units has resulted in a scarcity of connective tissue among treatment organizations and among levels of care within the same organization. There have existed thousands of self-encapsulated service units, but these could hardly be called a system of care.¹⁷⁰

The absence of a system undermines recovery initiation and stabilization and the successful transition to recovery maintenance. Each level of care and program has its own philosophy and service protocol that may or may not be congruent with levels of care that precede or follow it. Therapeutic alliance established with a helper in one level of care is not easily transferred to the next level of care, resulting in high attrition in the movement of individuals and families across levels of care. The development of P-BRSS, like case management before it, is in part an effort to create continuity of contact over time and across levels of care in a primary recovery support relationship.

CHARISMA AND RECOVERY

One of the special contributions some recovering people bring to the helping process is their zeal for passing recovery on to others. Many might be aptly described as recovery evangelists. Such enthusiasm constitutes a type of personal charisma. People possessing this “healing charisma” are described as self-assured, energetic, powerful, hypnotic, magnetic, devoted, and inspiring.¹⁷¹ They are practical and realistic, yet they elicit, through their words or deeds, hope for a new life. They offer themselves as living proof that such rebirth is possible.

The movement from addiction to recovery is often marked by extreme ambivalence, and those caught in this abyss often conduct pilot sobriety experiments before becoming fully committed to recovery. During this frequently prolonged process, they may enter treatment, not in search of recovery, but to manage their “habit” (by reducing drug tolerance), escape impending consequences, take a needed respite from the pressures of “the life,” and “audition” those providing treatment and recovery support.¹⁷² One of the

¹⁶⁹ Weisman, M. (1973). The para-professional in a medical setting. In G. E. Staub & L. N. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 66-77). Springfield, IL: Charles C. Thomas.

¹⁷⁰ Personal communication with Ron Hunsicker, CEO of the National Association of Addiction Treatment Providers, October, 2008.

¹⁷¹ Almond, R. (1974). *The healing community*. New York: Jason Aronson.

¹⁷² Koester, S., Anderson, K., & Hoffer, L. (1999). Active heroin injectors’ perceptions and use of methadone maintenance treatment: Cynical performance or self-prescribed risk reduction.

functions of P-BRS is the use of self and exposure to the recovery community to shift this motivational core from a focus on managing addiction to a focus on initiating and sustaining recovery.

Charisma within P-BRS involves many complex dimensions: personal attractiveness, honesty and candor (a “tell it like it is” style), immediate relief through concrete assistance, and the ability to provide sense-making stories and metaphors. Woodward and McGrath (1988) have set forth several propositions about the role of charisma in addiction recovery. These propositions, amplified by the author, include the following points:

- Exposure to charisma can be an asset and liability in the achievement of long-term addiction recovery.
- People who are physically depleted and emotionally dead from severe, prolonged alcohol and other drug problems may need a charismatic style of helping to successfully initiate recovery. (I am reminded here of Eric Hoffer’s¹⁷³ observation that the less justified a person feels in claiming value for self, the more ready he or she is to embrace a holy cause and follow a charismatic leader.)
- Those who benefit most from charisma in their recovery initiation efforts include those whose lives are marked by low self-esteem and self-efficacy, high levels of pain (high problem severity, complexity, and consequences), low levels of hope (severely depleted personal and family recovery capital), and prior relationships with charismatic figures.
- The need for charisma diminishes in the transition from recovery initiation to recovery stabilization and maintenance.
- Sustained styles of charismatic helping can actually retard the transition to recovery maintenance and enhanced autonomy and quality of life in recovery.

Several added points are worth noting here. First, recovery status alone does not necessarily ensure charisma, but charisma may be more available to people who are working within a framework of experiential knowledge. Second, charismatic styles of helping may be contraindicated for people with high levels of rationality, high levels of self-autonomy, or aversion to social fellowship. Recovery-based charisma may also produce unintended harm in the prevention and public education context. (See later discussion of problems associated with exposing young non-drug users to charismatic ex-addicts.) Third, the strategic use of charisma and the ability to lower or withhold charisma may be easier for peer helpers in late stages of recovery than for peer helpers who are at an early stage of recovery.

A key area of needed inquiry is the effect of charismatic encouragement by recovery role models on recovery initiation. The potential utility of this intervention rests on six points:

Substance Use and Misuse, 34(14), 2135-2153. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

¹⁷³ Hoffer, E. (1951). *The true believer*. New York: Harper & Row.

- 1) By the time people with severe AOD problems seek help, they have often experienced condemnation and rejection by society, social control agents (principals, police, judges, and probation officers), employers, and a host of non-specialized helpers.
- 2) Most of these social control agents demonstrate little hope for long-term recovery; addiction is highly visible in their work and community lives, but long-term recovery is often not visible from either position.
- 3) "It is quite possible that the remarkable lack of success reported in helping the alcoholic is directly related to the fact that the helping figure cannot, or does not, either by words or action, demonstrate confidence and faith in the patient's ability to change."¹⁷⁴
- 4) What recovering helpers bring to the encounter with those suffering from addiction is a profound sense of optimism about the prospects of recovery—a hope embodied in their own lives and their connection to a community of recovering individuals and families. Such hope stands as a "living refutation of the argument 'once an addict, always an addict.'"¹⁷⁵
- 5) The function of charisma is to incite hope and an extreme commitment; its mantra is "Recovery by any means necessary—under any circumstances."

In 1974, John Wallace proposed a related theory that informs the ability of peer specialists to adapt their personal styles of helping. Wallace outlined four linked propositions: 1) the alcoholic develops an elaborate preferred defense structure (PDS) (denial, minimization, black-white thinking, projection of blame, overcompensation) that supports continued drinking and grandiosity, 2) mechanisms within the PDS that support drinking must be maintained but realigned to support early recovery, 3) helping interventions that prematurely weaken the alcoholic's PDS may inadvertently precipitate relapse, and 4) the PDS that supported active drinking and is reframed to support recovery initiation must eventually be replaced with more mature defense mechanisms that support long-term recovery. The latter stage is marked by increased maturity, humility, self-acceptance, flexibility, and tolerance. Wallace's work suggests that the length and quality of sobriety may be predictive of those peer helpers who can strategically allocate personal inspiration in working with persons at different developmental stages of recovery, but suppress such charisma with those people for whom it would be contraindicated.

The role of P-BRS in leading estranged people back into relationship with mainstream communities is based on the assumption that the individual and the community benefit from such inclusion.

Metaphors of contagion (e.g., epidemic, plague, outbreak) have long been used to describe the rapid social transmission of AOD problems

¹⁷⁴ Falkey, D. B. (1964). Comment on Krystal, H. and Moore, R. Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol*, 25, 568-570.

¹⁷⁵ Kadushin, L. & Kadushin, A. (1969). The ex-addict as a member of the therapeutic team. *Community Mental Health Journal*, 5(5), 386-393, quote from page 389.

within local communities—particularly during periods of drug panic (Jenkins, 1994).¹⁷⁶ Recovery is also contagious—is socially transmitted—and can help stem surges in AOD use. A viable goal of AOD-related community intervention strategies is, in the absence of effective prevention, to shorten addiction careers and extend recovery careers. This requires effective strategies of sustained recovery management and service opportunities that turn people who were once addiction carriers into carriers of recovery.¹⁷⁷

Bratter,¹⁷⁸ for example, has argued that the self-awareness, maturity, focused dedication, and service ethic of recovering students make them a valuable asset to college campuses via their value of “responsible concern,” their ability to check the self-destructive tendencies of other students, and their frequent assumption of campus leadership roles.¹⁷⁹ Pursuing new educational goals has also been found to enhance success in achieving long-term recovery.¹⁸⁰ Belief in such reciprocal benefit to individual and community is a foundational idea of P-BRSS. This contagious ingredient through which recovery is transmitted from one person to another is “compassion, or as many recovered alcoholics simply put it, *love*.”¹⁸¹

Charisma also plays an important role in the evolution and vitality of peer recovery support organizations. While charisma may play a role in the birth of peer recovery support movements, the survival and health of such movements often rests on suppressing charismatic authority in favor of group consensus—a principle well-illustrated in the contrasting histories of Alcoholics Anonymous and Synanon.¹⁸²

¹⁷⁶ Jenkins, P. (1994). The ice age: The social construction of a drug panic. *Justice Quarterly*, 11(1), 7-31.

¹⁷⁷ White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58.

¹⁷⁸ Bratter, T. E. (1994). Bright, angry, recovering students: Their value to colleges. *Journal of College Admissions*, 142, 23-28.

¹⁷⁹ Bratter, T.E. & Parker, T.H. (1994). Bright, angry, recovering students: Their value to colleges. *The Journal of College Admission*, 142, 23-28.

¹⁸⁰ Rutledge, L. M. (2003). Education is a way out: Narratives of recovering addicts who utilized formal education as a part of their recovery journey. *Dissertation Abstracts International*, 64(10A), 3567.

¹⁸¹ Mann, M. (1973). Attitude: Key to successful treatment. In G. E. Staub & L. M. Kent (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas.

¹⁸² Borkman, T. (2006). Sharing experience. Conveying hope: Egalitarian relations as the essential method of Alcoholics Anonymous. *Nonprofit Management & Leadership*, 17(2), 145-161; Janzen, R. (2001). *The rise and fall of Synanon*. Baltimore: The Johns Hopkins University Press.

SPIRITUALITY AND RECOVERY

Profound religious or spiritual experience has often served as a catalyst for addiction recovery. Conversion-like experiences that are sudden, unplanned, positive, and permanent have long constituted a distinct pathway or style of addiction recovery. Experiences of such *quantum change* or *transformational change* are well documented in literature on the psychology of religion,¹⁸³ in the professional addictions literature,¹⁸⁴ in recovery biographies,¹⁸⁵ and in the literature of recovery mutual-aid societies.¹⁸⁶ The charisma of many of those providing P-BRS springs from such experiences.

Religious leaders extol the power of religious conversion as a vehicle of recovery, but tend to restrict the legitimacy of conversion experience to their particular faith or denomination frameworks. Non-recovering addiction service professionals and allied health and human service professionals bring widely varying attitudes toward religion and spirituality, but in this author's experience have as a group been highly skeptical of conversion experiences (sacred or secular) as a long-term solution to addiction. One of the distinguishing features of P-BRS and the work of P-BRSS specialists is a profound respect for the role of unseen forces and the power of religious, spiritual, and secular conversion experiences as triggers for recovery initiation. That respect comes from participation in communities of recovery within which the lives of some members have been saved and transformed through such experiences.

P-BRSS specialists drawn from membership in these communities do not need research studies to declare that such a style of recovery is possible. They have witnessed over extended time the fruits of transformative change. P-BRSS rest on the belief that developmental windows of opportunity exist in all of our lives—that profound breakthroughs in relationship to self, others, and/or God can forever cleave a life into the categories of before and after and reveal one's personal destiny. P-BRS and P-BRSS are about more than eliminating

¹⁸³ Begbie, H. (1909). *Twice-born men: A clinic in regeneration*. New York: Fleming H. Revell. Loder, J. E. (1989). *The transforming moment*. Colorado Springs, CO: Helmers and Howard. Starbuck, E. (1901). *The psychology of religion*. New York: Scribner's.

¹⁸⁴ Miller, W. R. & C'de Baca, J. (2001). *Quantum change*. New York: Guilford. White, W. (2004). Transformational change: A historical review. *IN SESSION: Journal of Clinical Psychology*, 60(5), 461-470.

¹⁸⁵ As samples, see Gough, J. (1870). *Autobiography and personal recollections of John B. Gough*. Springfield, MA: Bill, Nichols & Company. Offord, R. M. (1885). *Jerry McAuley: An apostle to the lost*. Harrisburg, PA: Publishing House of United Evangelical Church. Malcolm X & Haley, A. (1964). *The autobiography of Malcolm X*. New York: Grove.

¹⁸⁶ See Alcoholics Anonymous (1984). *"Pass It On": The story of Bill Wilson and how the AA message reached the world*. New York: Alcoholics Anonymous World Services. "Spiritual Experience," Appendix in Alcoholics Anonymous (1976). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. New York City: Alcoholics Anonymous World Services, Inc., pp. 569-570.

destructive alcohol and drug use; they are about helping people find meaning and purpose whose lives have been wounded and emptied by such use.

STORYTELLING AND THE POWER OF MUTUAL IDENTIFICATION

Exposure to the personal stories and lives of people in recovery can serve as a catalyst of personal transformation for people suffering from severe AOD problems.

They [reformed men] understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard's heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform... (From the Mercantile Journal, May 27, 1841)¹⁸⁷

We were once as you are: come with us and be cured. (Bi-Chloride of Gold Club/Keeley League, 1891).¹⁸⁸

He gave me information about the subject of alcoholism which was undoubtedly helpful. Of far more importance was the fact that he was the first living human with whom I had ever talked, who knew what he was talking about in regard to alcoholism from actual experience. In other words, he talked my language. He knew all the answers, and certainly not because he had picked them up in his reading. (Dr. Bob S. referring to his first meeting with Bill W.—co-founders of Alcoholics Anonymous).¹⁸⁹

...the ex-addict paraprofessional could speak the client's language since he or she shared the same life experiences and background, would be sensitive to manipulation, and was able to act as a role model for the client, i.e., as someone who had been "in the life" and emerged from it successfully.¹⁹⁰

What the recovered alcoholic counselor can do that no one else can do is to be a role model of successful recovery for a sick patient.¹⁹¹

¹⁸⁷ Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.

¹⁸⁸ Barclay, G. (1964). The Keeley League. *Journal of the Illinois State Historical Society*, 57, 341-365.

¹⁸⁹ *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (Third edition). (1976). New York City: Alcoholics Anonymous World Services, Inc.

¹⁹⁰ Brown, B. S. (1993). Observations on the recent history of drug user counseling. *The International Journal of the Addictions*, 28(12), 1243-1255.

¹⁹¹ Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

*By “speaking the same language,” backed up with common experience, the [recovering] counselor is often able to affect the first breakthrough in such patients [those having problems with authority figures]. He is then able to lead the patient into realistic relationships with the other members of the team.*¹⁹²

This use of self crosses recovery traditions, whether in the form of *witnessing* or *testifying* within faith-based traditions; the sharing of experience, strength, and hope within spiritual traditions; or the simple exchanging stories and strategies within secular recovery traditions.

The emphasis on reciprocal self-disclosure and mutual identification in P-BRSS is in marked contrast to the debate surrounding self-disclosure in psychotherapy¹⁹³ and addiction counseling,¹⁹⁴ where such disclosure has been discouraged except under strict clinical guidelines. In contrast, peer helpers often view self-disclosure of their recovery story as self-reparation, an offering of hope to those still suffering, and an instrument of public education that might counter social stigma and widen the doorways of entry into recovery for others. People in recovery must weigh the benefits of such disclosure to individuals, families, and communities against the risks of such disclosure for themselves and their own family members.¹⁹⁵ Guidelines for self-disclosure are being developed for those recovering from addiction and from mental illness.¹⁹⁶

The self-disclosure debate reflects a broader difference in the degree of personal involvement in the helping relationship by the peer specialist.

The peer encounter is neither narrowly rule-directed nor reflexive; each participant must think, evaluate various alternative actions, and interpret the other's actions.... Consequently, [peer] support providers must always evaluate how much to invest emotionally and how much to refrain from investing. They must decide how much they want to be distanced from the recipient by the veil of objectivity and detachment versus how much

¹⁹² Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In B. Kissin & H. Beglieter (Eds.), *The biology of alcoholism, Vol. 5, treatment and rehabilitation of the chronic alcoholic* (pp. 545-565). New York: Plenum Press.

¹⁹³ Barrett, M. S. & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, 69(4), 597-603.

¹⁹⁴ Chapman, C. (2000). Ethical issues in the use of self-disclosure for substance abuse professionals. *The Counselor*, 18, 18-22. Dickerson, L. (1989). Should recovering professionals self-disclose? *Professional Counselor*, 3, 47-65. Mallow, A. J. (1998). Self-disclosure: Reconciling psychoanalytic psychotherapy and Alcoholics Anonymous philosophy. *Journal of Substance Abuse Treatment*, 15(6), 493-498. Roes, N.A. (2004). The rules of self-disclosure. *Counselor*, 5, 26-28.

¹⁹⁵ Corrigan, P. (2003). Beat the stigma: Come out of the closet. *Psychiatric Services*, 54(10), 1313.

¹⁹⁶ See http://www.facesandvoicesofrecovery.org/publications/recovery_messaging/index.php. Hyman, I. (2008). Self-disclosure and its impact on individuals who receive mental health services. HHS Pub. No. (SMA) 08-4337. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

*they want to be emotionally invested through empathy, compassion, and caring. This means that support providers must work at finding a balance between the pitfalls of indifference (i.e., detached, bureaucratic helping) and enmeshment (i.e., biased, overly emotional helping), which involves determining the boundaries of the relationship....*¹⁹⁷

The peer's degree of personal involvement is a strength and vulnerability of P-BRSS. The distancing maneuvers of treatment professionals are intended to ensure objectivity in assessment and counseling, reduce the risk of exploitation in the helping relationship, and minimize the effects of vicarious traumatization (VT)—also known as secondary traumatic stress. VT occurs when helpers lack the defenses necessary to protect themselves against the emotional impact of helpees' stories of victimization, degradation, and/or perpetration. Diagnostic schemes, theoretical models, manual-guided service protocols, therapeutic techniques, ethical codes, and brief service relationships all serve as protective shields for the professional. In the world of peer support, the helper has greater levels of emotional exposure.

For the P-BRSS specialist, protection comes not from intellectualization of the horror to which one may be exposed, or by personal distancing, but through support for the helper and helpee from a larger recovery community. In other words, the emotional intensity of reciprocal self-disclosure and the intimacy produced by such disclosure are diffused within a larger community of mutual support. When peer helpers work in isolation from this support, they may injure themselves through the helping process. Some stories are so horrific that their poisons cannot be emotionally digested by the peer helper. This is why, in recovery communities, members are expected to tell "in a general way what we used to be like, what happened, and what we are like now"¹⁹⁸ and leave the disclosure of the more intimate details in their life stories to fifth steps, religious confession, or psychotherapy.

The use of self-disclosure, mutual identification, and the absence of contempt are such important components of the recovery-focused helping relationship that special strategies have been suggested to help professionals not in recovery achieve these ingredients. In 1940, Howard and Hurdum¹⁹⁹ went so far as to suggest that all professional helpers working with alcoholics should be abstinent, including those with no history of alcohol problems.

It is essential that complete abstinence be advised to the patient. Accordingly it is advisable that the therapist himself abstain, lest his acts

¹⁹⁷ Bacharach, S. B. (2000). Boundary management tactics and logics of action: The case of peer-support providers. *Administrative Science Quarterly*, 45, 704-736, quotation from p. 704.

¹⁹⁸ Alcoholics Anonymous (1939). *Alcoholics Anonymous: The story of how more than one hundred men have recovered from alcoholism*. New York City: Works Publishing Company.

¹⁹⁹ Howard, C. & Hurdum, H. (1940). Therapeutic problems in the alcoholic psychoses. *Psychiatric Quarterly*, 14(2), 347-359.

or attitude seem to imply “you must not drink, but it is all right for me to do so as I am a superior person.”²⁰⁰

Program Profile 11: Storytelling Training (Philadelphia, PA)²⁰¹
Purpose: Storytelling Training is supportive, skills-based training for persons in recovery, to assist them in developing their own recovery stories and to boost their confidence in presenting their stories in public venues. The 4 ½-hour training session is held once a month.
Service Elements: 1) Introduction to recovery-focused systems transformation process; 2) story presentation guidelines and tips for different audiences; 3) storytelling practice with support and feedback; 4) discussion of story presentation opportunities.
Service Volume/Status: As of November, 2008, 31 Storytelling Training sessions have been conducted, involving 370 participants; four Family Storytelling Training sessions have been conducted for 100 participants.
Service Outcomes: 1) Graduates of Storytelling Training have been invited as presenters in various recovery-oriented trainings, conferences, and other community education events; 2) Storytelling Training has served as portal of entry to other training and service opportunities; 3) some graduates have gone on to obtain employment in the behavioral health field.
Service Lessons: 1) Storytelling Training has had unintended positive consequences for the participants and the system, including dramatic levels of personal empowerment and personal networking, and enhanced involvement and effectiveness of graduates in other systems-transformation activities; 2) the training is an exceptional tool for building relationships among people in recovery.
For More Information: Contact Seble Menkir at seble.menkir@phila.gov or 215-685-5498.

STIGMA AND THE DYNAMICS OF HELP-SEEKING

Peer recovery support is a potential antidote to the barriers people encounter in seeking professional help for severe AOD problems.

*The only professional who will stop for a drunk on the street is a policeman.*²⁰²

²⁰⁰ Howard, C. & Hurdum, H. (1940). Therapeutic problems in the alcoholic psychoses. *Psychiatric Quarterly*, 14(2), 347-359.

²⁰¹ Personal communications with Ellen Faynberg and Joan King, November 2008.

²⁰² Staub, G. & Kent, L. (1973). Thoughts to ourselves. In G. E. Staub & L. M. Kent. (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas.

*I wonder if you or other helping professionals remember what it is like to ask for help...with nothing more than your own personhood as the reason for anyone's lifting even a little finger to provide assistance...Could it be that in order to be able to give help you should first learn how to receive help?*²⁰³

*Help receiving is a difficult role. It tends to underline one's inadequacy...The new paradigm calls for the restructuring, redistribution, and expansion of helping behavior by those who ordinarily function as consumers of help.*²⁰⁴

If there is a single condition that has spawned the historical involvement of recovering people in service work, it is the contempt with which society and mainstream service professionals have viewed those suffering from alcohol and other drug addiction.

*Contempt, often mutual, is an enduring and troubling theme in the historical relationship between helping professionals and addicts. The addiction treatment industry as a specialized field grew out of the contempt in which other helping systems regarded alcoholics and addicts. For generations, physicians, nurses, social workers, psychologists, welfare workers, and other service professionals barely masked their contempt for the alcoholic and addict. Beneath the veneer of professional discourse about addicts during the past century lies a pervasive undertone: Most professionals simply do not like alcoholics and addicts.*²⁰⁵

By altering these conditions, peer-based supports provide adjuncts or alternatives to professional assistance that can expand help-seeking, enhance the quality of the helping experience, and improve the stewardship of scarce community resources.²⁰⁶

If there is an inner core to the experience of addiction, it is a core of shame and the anguish and despair that flow from it.²⁰⁷ That shame has many sources—the stain of experiencing oneself as unworthy and unlovable, the sins committed in the worship of one's sacramental drug, and the pariah status of anyone forced to embrace the caricatured label of alcoholic or addict. Those so condemned can catch the briefest condemnation in the eyes, the faintest tone of judgment and condescension in the voice, and the slightest hesitation to reach for an extended hand. Peers understand such shame. Their eyes dance with

²⁰³ Morgan, C. A. (1987). I, the client. In G. Gandy (Ed.), *Rehabilitation counseling and services: Profession and process* (pp. 234-243). Springfield, IL: Charles C. Thomas.

²⁰⁴ Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry*, 18(2), 221-230.

²⁰⁵ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

²⁰⁶ Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry*, 18(2), 221-230.

²⁰⁷ Personal communication with Dr. Garrett O'Connor, January 2009.

understanding, their voices offer a balm of profound empathy, and their touch is a welcoming embrace of inclusion and hope for redemption.

What recovering people have long brought to their service work is a relationship based on moral equality, respect, emotional authenticity, and a “kinship of common suffering.”²⁰⁸

*The drunkard is now regarded in a new light....Instead of being considered a cruel monster—a loathsome brute—an object of ridicule, contempt and indignation, as formerly, we are now taught to look upon him as a brother...as a slave to appetite, and debased by passion—yet still as a man, our own brother.*²⁰⁹

*...we use the Socratic Method—we don’t teach by lecturing, we teach by asking questions that help them [those reached through outreach] answer the questions themselves....Most addicts like me have had bad experiences with authority figures: doctors, police, teachers, parents. We tend to not trust people in general. So we try to let group members see that we’ll give them straight talk, aren’t interested in judging them, and that it wasn’t so long ago that we peer educators were walking in their shoes.*²¹⁰

*I like for you to extend your hand across to me—not down to me. In the warmth of your clasp I want to sense you saying, “As one human being to another, we are in this fight together. We are joined in problems that in one form or another continue to pester me, too.” When this happens and you have really come alive as a person, then I’ll be in a lot better mood to listen to what you have to offer.*²¹¹

Professionals who have not been humbled by their own moments of reckoning can offer many things, but the one thing they can never extend to the suffering addict is the word “we.” The experience of “we” is the healing balm offered by those who may lack qualifications of education and professional training.

The task of the professional addictions counselor is to recognize any existing feelings of judgment, aversion—even repulsion—as components of a process of countertransference. Such feelings require expression within the clinical supervision process, to reduce their presence within and impact upon the service relationship. Similarly, not all peers share the same level of empathy with and acceptance of those they serve. For example, the pecking order within American cultures of addiction (and, in fact, within any stigmatized group) can

²⁰⁸ Alcoholics Anonymous (1957). *Alcoholics Anonymous comes of age*. New York: A.A. World Services, Inc.

²⁰⁹ A Member of the Society. (1842). *The foundation, progress and principles of the Washingtonian Temperance Society of Baltimore, and the influence it has had on the temperance movements in the United States*. Baltimore: John D. Toy.

²¹⁰ Galindo, L., Maginnis, T., Wallace, G., Hansen, A., & Sylvestre, D. (2007). Education by peers is the key to success. *International Journal of Drug Policy*, 18(5), 411-416.

²¹¹ Morgan, C. A. (1987). I, the client. In G. Gandy (Ed.), *Rehabilitation counseling and services: Profession and process* (pp. 234-243). Springfield, IL: Charles C. Thomas.

generate negative emotions that are as injurious as those elicited by some professionals. Recovering peers drawn from these cultures can unconsciously bring these past attitudes into their service relationships, e.g., the historical superiority of the “righteous dope fiend” over the “gutter hype,” the “alcoholic” over the “wino,” and the “snowbird” over the “crack whore.” Such elitism “among the damned” was evident in early recovery support societies that wanted only “drunkards of good repute” to be members of their societies.²¹² Peers, like professionals at their best, must find ways to transcend sources of bias that corrupt the helping process. The challenge for the peer is to strive for the utter openness and acceptance that flows from the “we” position and to recognize and support people through, rather than rescuing them from, the authentic suffering that is so often critical to recovery.²¹³

The transition from a professional to a peer orientation—from hierarchical to reciprocal relationships—is well illustrated in the shift within recovery schools (recovery programs established within secondary and collegiate educational institutions) from the use of professionally directed therapy groups to “talking circles.”

*Participants sit in a circle, and a keeper or facilitator (either staff or student) opens the circle, welcomes everyone, and passes a talking piece. The person who has the talking piece gets to speak, hold it in silence, or pass it on. Everyone else gets to listen...Everyone is heard, everyone listens....In the circle, the youth feel they can speak truthfully because all are treated equally, people can pass without serious consequences, and confrontation is replaced by deeper listening. It is a safe place.*²¹⁴

The peer recovery support relationship is contingent on escaping the asymmetry of power that exists in the professional helping relationship. Historically, P-BRS models reject language describing peer-helping that injects such asymmetry—words like *treatment, clinical, diagnosis, counseling, therapy, therapeutic*. The language of P-BRS is demystified and egalitarian: *helping, supporting, guiding, and assisting*.²¹⁵ An ethnographer comparing the milieu of a P-BRSS organization and a professional treatment organization would be struck by their differences in language, with the former describing engagement using words rarely heard in clinical settings.

It takes time to engage people who've been beaten down for so long. They have to check us out to see if we're one of those places just in it for the money. They have to find out if there's something to us or if this is

²¹² White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

²¹³ Personal communication with Dr. Garrett O'Connor, January 2009.

²¹⁴ Riestenberg, N. (2007). The restorative recovery school: Countering chemical dependency. *Reclaiming Children and Youth*, 16(2), 21-23.

²¹⁵ Hiltner, S. (1964). Comment on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol*, 25, 354-357.

some kind of hustle. Trust and understanding is what hooks them and keeps the recovery process moving forward. And this is not about forms or techniques; it's about that eye-to-eye and heart-to-heart connection. It's about using honesty and love to get inside somebody. My stance is, "you can bullshit me, but I will know you're bullshitting and still love you. And I'll hang in with you 'til you decide to get real." I show them that a different way of living is possible. (Samuel Morales, Outreach Specialist, New Pathways Project, Philadelphia, PA)

Program Profile 12: Taking Recovery to the Streets (Philadelphia, PA)²¹⁶
<i>Purpose:</i> 1) To test the feasibility of training people in recovery to provide recovery education to people seeking treatment and recovery support services, 2) to provide service opportunities for people in recovery, 3) to engender hope and basic knowledge about recovery in service recipients by using recovery role models and their experiential wisdom. (Program started in 2007)
<i>Service Elements:</i> 1) Training and certification program for recovery ambassadors, 2) presentations at treatment and rehabilitation programs, shelters/safe havens/cafes and local conferences.
<i>Service Outcomes:</i> 1) 21 people in recovery have been trained and certified, 2) 12 behavioral health organizations have sponsored presentations to their clients, 3) peer support relationships have developed between presenters and participants, 4) stipends paid for the presentations provide supplemental income for individuals/families in recovery, 5) four of the presenters have become certified peer specialists and are now working at a behavioral health organization.
<i>Service Lessons:</i> 1) The central message of systems transformation—the hope for long-term recovery—can be best conveyed by people in long-term recovery, and the recovery message is being delivered by people in recovery directly to people seeking recovery; 2) there is a need to identify and train bilingual people in recovery as ambassadors; 3) recovery ambassadors might be a major system-wide resource and a resource for recovery-focused education of the larger community.
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SHARING RECOVERY CAPITAL

Recovery capital, a concept developed by Granfield and Cloud, is the sum total of internal and external resources that can be mobilized to initiate and sustain long-term addiction recovery.²¹⁷ The concept is related to the idea of

²¹⁶ Tom O'Hara, Personal Communication December, 2008.

²¹⁷ Granfield, R. & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press; Cloud, W. & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use and Misuse*, 43(12), 1971-1986.

“social margin,” defined by Wiseman²¹⁸ as “the leeway a given individual has in making errors...without suffering serious penalties such as being fired, denied credit, or losing friends or family.” Recovery capital and social margin include credits earned in relationships with others that can be cashed in for support during the effort to recover from addiction. Individuals with high problem severity/complexity/chronicity and low recovery capital face significant obstacles to their recovery, due to their depleted internal assets and exhausted social credit.²¹⁹ Such people are aptly described as having “burned their bridges.”

A key activity of the P-BRSS specialist is to “lend” those seeking recovery some of the peer’s own recovery capital and social credit until such time as the recovery seeker can regenerate his/her own personal and social assets. This capital/credit can span traits and attitudes (hope, determination, and confidence), resources (clothing, food, money, and shelter), and relationships (social connections with conventional society and spiritual connections to sources of power outside the self).²²⁰ *Giving* recovery capital would be a form of charity exchange involving roles of authority and submission; *sharing* recovery capital is a transaction between equals through which new personal assets are created for both parties. Debts incurred by the person being helped can be repaid later by returning such support to the helper or passing it on to others.

THE HELPER THERAPY PRINCIPLE

The peer helping process is reciprocally beneficial: the helper and helpee draw value from helping exchanges. The helper therapy principle originally set forth by Riessman²²¹ states simply that, in the course of helping others, one’s own problems diminish. What one receives as a recipient of P-BRSS is not charity, but an exchange from which both parties benefit. Equality of power and reciprocity of benefits are essential ingredients of P-BRS. What is needed—and in fact has long existed in recovery mutual-aid societies—is a cooperative learning environment in which helping and being helped are reciprocal and widely distributed.²²²

The ...strategy ought to be to devise ways of creating more helpers! Or, to be more exact, to find ways to transform recipients of help into dispensers of help, thus reversing their roles, and to structure the

²¹⁸ Wiseman, J.P. (1979). *Stations of the lost: The treatment of skid row alcoholics*. Chicago: University of Chicago Press.

²¹⁹ White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27.

²²⁰ Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, 16(3), 321-337. Fagan, R. & Mauss, A. (1986). Social margin and social reentry: An evaluation of a rehabilitation program for skid row alcoholics. *Journal of Studies on Alcohol*, 47, 413-425.

²²¹ Riessman, F. (1965). The “helper” therapy principle. *Social Work*, April, 27-32.

²²² Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry*, 18(2), 221-230.

*situation so that recipients of help will be placed in roles requiring the giving of assistance.*²²³

*People can find capital in their troubles and use them to provide access to leadership, livelihood in the clientele organizations or entrée into the profession that services the group.*²²⁴

Alcoholics Anonymous has capitalized on the helper principle through its practice of sponsorship. Similarly, new recovery community centers are blurring the line between helper and helpee by encouraging all participants to give and receive support from one another, on the assumption that everyone brings needs and assets. Acts of helping afford opportunities for 1) introspection and insight—seeing oneself freshly in the experience of the other, 2) extracting important life lessons via the self-disclosure process, 3) resolving one's own ambivalence by persuading others, 4) enhanced physical and emotional health, 5) achieving the social status inherent in the helper role, and 6) envisioning the potential for new roles and opportunities.²²⁵ The positive effects of helping on recovery are confirmed in multiple studies (see chapter four) and even exert positive effects on active drug users.²²⁶

INDIVIDUAL, COMMUNITY, CULTURE

In culturally besieged communities, hope for individuals and families must be couched in a broader vision of hope for a people; in all communities, understanding the ecology of recovery is key to the design of effective P-BRSS. P-BRSS, at their best, supplement intrapersonal interventions with efforts to anchor recovery within each client's natural environment or, failing that, create an alternative environment in which recovery is possible.

*In the Red Road to Wellbriety, the individual, family and community are not separate; they are one. To injure one is to injure all; to heal one is to heal all.*²²⁷

*We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.*²²⁸

²²³ Riessman, F. (1965). The "helper" therapy principle. *Social Work, April*, 27-32.

²²⁴ Gusfield, J. (1982). Deviance in the welfare state: The alcoholism profession and the entitlements of stigma. *Research in Social Problems and Public Policy*, 2, 1-20.

²²⁵ Riessman, F. (1965). The "helper" therapy principle. *Social Work, April*, 27-32; Thoits, P. A. & Hewitt, L. N. (2001). Volunteer work and well being. *Journal of Health and Social Behavior*, 42, 115-131. Zembre, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, 100(4), 447-450.

²²⁶ Latkin, C.A. (1998). Outreach in natural settings: The use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Reports*, 114, Supplement 1, 151-159.

²²⁷ White Bison. (2002). *The red road to wellbriety*. Colorado Springs, CO: White Bison, Inc.

²²⁸ Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge.

Organizations that promise to rehabilitate or cure people with AOD problems and return them to the family/community often end up further isolating those individuals from the family/community. The greater the physical, psychological, and cultural distance between a helping organization and the natural environment of the person being helped, the greater will be the difficulty transferring learning from the former to the latter.²²⁹ P-BRSS provide a vehicle to close this gap by forming a bridge between professional and natural environments and by developing and mobilizing recovery supports within each person's natural environment. P-BRSS, rather than focusing solely on intrapersonal healing, focus on guiding marginalized individuals and families back into the lives of their local communities.²³⁰

P-BRS enhances the effectiveness of professional helping agencies, in part by building bridges of community involvement for those who have lived as cultural outsiders. Achieving that feat requires sustained involvement of the P-BRSS specialist in networks of community relationships—a style of involvement that can be threatened by professionalism of the P-BRSS role. The following view of the administrator of a street outreach program utilizing “paraprofessional ex-addicts” exemplifies this potential:

*...any overserious assumption of middle-class roles by the workers could seriously jeopardize their effectiveness and would undercut the fundamental rationale of an effort employing former addicts, knowledgeable in the ways of addiction, to help practicing addicts.*²³¹

Kaufman, in his study of the use of ex-addicts in prisons, similarly notes the tension between what the ex-addict helper needs for his own stability and recovery (e.g., to break contact with drug-copping neighborhoods) and what is needed as a helper to others (e.g., sustained sensitivity to the culture and folkways of those neighborhoods).²³²

Ideally, P-BRSS flow from the cultural and geographic communities being served. The individuals providing the services are vetted by the community. The services themselves are designed by and for the community and tap indigenous recovery support resources within the community. Also, the community leaders and stakeholders have a role in valuing as well as evaluating the services. Where justifying claims of “evidence-based” practices rely on external authority,

²²⁹ White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58.

²³⁰ McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books. Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, 49(4), 550-561.

²³¹ Bullington, B., Munns, J., & Geis, G. (1969). Purchase of conformity, ex-narcotic addicts among the bourgeoisie. *Social Problems*, 16(4), 456-63.

²³² Kaufman, E. (1978). The use of ex-addicts and other paraprofessionals as mental health workers in prison. *Diseases of the Nervous System*, 37(12), 679-682.

“culturally vetted” services rely on a community stamp of approval via the community’s indigenous leaders and community storytelling.²³³

Addiction can be a manifestation of estrangement from the community or generate such estrangement over time. Peer recovery support provides a framework for reconciliation in the person-community relationship. Folgheraiter and Pasini refer to this process as “civic recovery” and refer mutual-aid groups as a “gym for active citizenship.”²³⁴ P-BRS provides an incubation chamber in which the person-community relationship can be repaired and reconstructed. The essential ingredients in this process are self-inventory, confession of harm to community, acts of restitution, and acts of service.

CULTURES OF ADDICTION AND RECOVERY

Addiction and recovery, and the transition from the former to the latter, can be as much a physical and cultural journey as an intrapersonal journey.²³⁵ There are elaborate cultures of addiction and cultures of recovery—mirrored in their organization by age, gender, ethnicity, social class, sexual orientation, drug choice, and neighborhood—that respectively support one’s addiction or recovery status. Individuals can be as dependent upon the culture of addiction—its language, values, roles, rituals, and relationships—as they are on the drugs that form the centerpiece of that culture. Individuals deeply enmeshed in a culture of addiction may need to become equally enmeshed in a culture of recovery during recovery initiation, and may need a guide to help them make the journey from one culture to the other.²³⁶ The P-BRSS specialist, who is knowledgeable but not defensive about local communities of recovery, can offer such guidance.²³⁷

*Junk is not just a habit. It is a way of life. When you give up junk, you give up a way of life.*²³⁸

²³³ White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, 26(3), 365-395.

²³⁴ Folgheraiter, F. & Pasini, A. (2009). Self-help groups and social capital: New directions in welfare policies. *Social Work Education*, 28(3), 253-267.

²³⁵ Agar, M. (1977). *Ripping and running: A formal ethnography of urban heroin addicts*. New York: Seminar Press, Inc. Spradley, J. (1970). *You owe yourself a drunk: An ethnography of urban nomads*. Boston: Little, Brown & Company. Waldorf, D. (1973). *Careers in dope*. Englewood Cliffs, NJ: Prentice-Hall, Inc. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

²³⁶ White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

²³⁷ Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In B. Kissin & H. Beglieter (Eds.), *The biology of alcoholism, Vol. 5, treatment and rehabilitation of the chronic alcoholic* (pp. 545-565). New York: Plenum Press. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

²³⁸ Burroughs, W. (1953). *Junkie: Confessions of an unredeemed drug addict*. New York: Ace Books.

Because of the P-BRSS specialist's intimate knowledge of the cultures of addiction and recovery, as well as of the addiction/recovery experience, he or she is in an ideal position to serve as a bridge—an interpreter, liaison, and advocate—in the relationship between the professionally trained therapist and individuals entering addiction treatment. P-BRSS specialists approach those they serve from the position of cultural insider: one knowledgeable of the culture of addiction and, more important, one who can serve as a guide through the pathways of egress from this culture, an egress that involves the translation of knowledge and skills from one world to the other.

PREVENTING HARM IN THE NAME OF HELP

Within the history of addiction treatment and recovery there is a long history of harm inflicted in the name of help.²³⁹ P-BRSS are not immune from such potential for harm. Safeguards must be taken to reduce these risks.²⁴⁰

The first step in such protection involves the selection of peer specialists, whether they operate in paid or volunteer roles. Advocates of P-BRSS do not suggest that ALL persons in recovery are by their recovery status qualified to help those addicted to alcohol and other drugs. Some individuals in recovery are too damaged by their addiction or are characterologically unsuited (e.g., impatient, dogmatic, unsympathetic, intolerant, critical, manipulative, exploitive) for such a role.²⁴¹ Others are simply too immature and self-involved to function as peer helpers.

A person who after some years of sobriety still attends AA seven nights a week, has not yet learned to play, relates poorly to the opposite sex and to family, and has little interest in anything other than alcoholism is scarcely an ideal candidate [for an alcoholism counselor].²⁴²

Since the “paraprofessional” days of addiction counseling, concerns have been raised about the potential harm that might come from peer models of helping. Even early advocates of employing ex-addicts as counselors cautioned about problems related to nepotism, financial malfeasance, sexual exploitation of

²³⁹ White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals, *Counselor*, 9(6), 10-17.

²⁴⁰ For findings on inadvertent harm from peer-based prevention models, see Valente, T.W., Ritt-Olson, A., Stacy, A., Unger, J.B., Okamoto, J. & Sussman, S. (2007). Peer acceleration: effects of a social network tailored substance abuse prevention program among high-risk adolescents. *Addiction*, 102(11), 1804-15.

²⁴¹ Root, L. (1973). In-service training of the para-professional in the field of alcoholism. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 40-57). Springfield, IL: Charles C. Thomas Publisher.

²⁴² Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

clients, and other ethical problems that might arise when ex-addicts were placed in positions of authority without adequate supervision.²⁴³

These concerns may be magnified in peer-support models for adolescents. Same-aged peers may be looked upon with suspicion by parents and/or treatment staff, or regarded as not mature enough or as not having sufficient recovery time, and older peers may be looked upon with suspicion out of fears that they might take advantage of younger adolescents seeking recovery.²⁴⁴ Concerns have also been raised about ex-addicts employed in schools as agents of drug prevention,²⁴⁵ particularly the concern that the charismatic young ex-addict might inadvertently “turn the adolescent non-drug user on to drugs through his attractive role modeling.”²⁴⁶

In determining the potential of the P-BRSS specialist for help or harm, it is important that such determinations be made based on a judgment of each individual rather than on sweeping stereotypes, whether those stereotypes are of a positive or negative nature. As Dr. Donald Louria noted in 1973:

*...whether in rehabilitation, community services, or education, the ex-addict's role must be determined on an individual basis. Some have the capacity to do a very good job and their drug experiences, incorporated into their formal roles, augments that capacity. Others are mediocre and still others are poor and should be encouraged to focus on job opportunities outside the arena of drug abuse.*²⁴⁷

Efforts to prevent inadvertent harm within P-BRSS include careful screening and selection of staff and volunteers and orientation, training, and supervision of P-BRSS that emphasize practicing within and only within the boundaries of one's education, training, experience, and role. Some recovery community organizations have clarified the roles of recovery coach, sponsor, and addiction counselor²⁴⁸ and articulated core recovery community values (and ethical guidelines) to guide the actions of P-BRSS specialists.²⁴⁹

²⁴³ Siassi, I., Angle, B.P., & Alston, D.C. (1977). Who should be counselors in methadone maintenance programs: Ex-addicts or nonaddicts? *Community Mental Health Journal*, 13(2), 125-132. Weppner, R. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 103-105.

²⁴⁴ Lora Passetti, Personal communication, December, 2008.

²⁴⁵ Kline, J.A. & Wilson, W.M. (1972). Ex-addicts in drug abuse prevention education. *Drug Forum*, 1(4), 357-366.

²⁴⁶ Gerber, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 105-106.

²⁴⁷ Louria, D. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 106-109.

²⁴⁸ White, W. (2007). The new recovery advocacy movement in America. *Addiction*, 102, 696-703.

²⁴⁹ Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumers-providers: Barriers and alternative solutions. *Community Mental Health Journal*, 37(3), 199-213. White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits, R. & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

Another aspect of harm in the name of help involves potential injury to individuals in recovery who work in volunteer or paid recovery support roles. Such injury can come from:

- The emotional strain accompanying efforts to help individuals with severe and complex problems;
- Role ambiguity, role conflict, role overload, and inadequate role feedback experienced in the role of recovery coach;²⁵⁰ and
- Role safety concerns and exposure to drug-using cues for those working as outreach workers.²⁵¹

All of these conditions can heighten vulnerability to relapse among recovering people working in P-BRSS roles. (See chapter six for studies on relapse rates.) Such vulnerability can be reduced via length-of-recovery requirements; care in screening and selection; and effective orientation, training, and supervision.

STEWARDSHIP OF COMMUNITY RESOURCES

P-BRSS constitute a delivery device for long-term recovery support that can enhance recovery outcomes at costs far lower than those that would be necessary to provide sustained professional care. As the financial resources allocated to addiction treatment erode, P-BRSS are being considered as cost-effective alternatives to professional treatment for people with low-to-moderate problem severity and as ways of supporting the recovery of people with high problem severity and complexity who have received professional treatment. Put simply, P-BRSS are cost effective and contribute to better recovery outcomes. Dr. Tom Kirk, Commissioner of the Connecticut Department of Mental Health and Addiction Services, recently affirmed this rationale.

When we examined our service utilization data, we found that 20 percent of our behavioral health clients were consuming approximately 80 percent of our resources by repeatedly recycling through our most acute and expensive levels of care. Our investment in recovery support services was an attempt to generate better recovery outcomes. We are finding ways to use intensive case management and peer support to reduce excessive service utilization and increase recovery outcomes for this group of clients, and to divert the dollars we are saving through this effort to invest in recovery support service programs (Thomas Kirk, Personal communication, September, 25, 2008).

²⁵⁰ White, W. (1979). *Relapse as a phenomenon of staff burnout in recovering substance abusers*. Rockville, MD: HCS, Inc.

²⁵¹ Wiebel, W.W., Biernacki, P. Mulia, N. & Levin, L. (1993). Outreach to IDUs not in treatment. In B. Brown and G. Meschner (Eds.), *Handbook on Risk of AIDS: Injection drug users and sexual partners*. Westport, CT: Greenwood Press. Woods, M.G., Shorty, V., Jones, A., Ingram, P.W., Douglass, B.D. & Dennis, M. (ND). Outreach workers: Theory and a practical application. Unpublished manuscript.

To recovery advocates, treating addiction with serial episodes of expensive acute stabilization without sustained recovery support services is like treating a bacterial infection with only half of the needed antibiotics. The symptoms may disappear temporarily, but the condition is likely to return in a more virulent and intractable form.

This monograph has been written in the midst of a collapsing American housing market, plummeting stock values, declining city and state tax revenues, and much talk about a sustained economic recession, all ushering in a new era of fiscal austerity. In these conditions, professional treatment resources are shrinking, and some policymakers and administrators are suggesting that the movement toward peer-based support services and the broader transformation to a recovery focus should be slowed or postponed until the economy improves.

Recovery advocates believe that these times offer a real opportunity to transform the way in which help is delivered to people seeking recovery. Peer-based recovery support services complement existing professional treatment, increasing its effectiveness and providing more opportunities for sustained recovery. These supports, provided through service organizations, are complemented by recovery mutual-aid societies. It is interesting to note that the economic condition we find ourselves in today is similar to that which saw the rise of Alcoholics Anonymous during the Depression.

Pathways to recovery, including professional treatment, must be built on a foundation of indigenous recovery support that is not vulnerable to the vagaries of policy shifts and economic cycles. How many local addiction treatment programs have disappeared during the decades in which peer-based mutual-aid societies like AA have maintained continuous existence and accessibility?

THE THREATS OF ANTI-PROFESSIONALISM AND PROFESSIONALISM

As a recovery orientation evolves, including the expanded use of peer-based recovery support services, there are two threats to this important movement. The first risk lies in the propensity for anti-professionalism, “incestuous closure,” and organizational implosion.²⁵² While intertwined with one another and integral to recovery success, P-BRSS and professionally directed addiction treatment services are grounded in fundamentally different ways of knowing. Both face similar threats as they evolve. The first is the danger of casting their way of knowing and what has been learned through that method as the *whole* truth.

In closed systems, organizational beliefs are transformed into a holy cause. Ideologies are not just defined as true; they are defined as THE Truth—one that is whole and fully evolved. Any proposed alteration is

²⁵² Janzen, R. (2001). *The rise and fall of Synanon*. Baltimore: The Johns Hopkins University Press. Riessman, F. (1965). The “helper” therapy principle. *Social Work, April*, 27-32. White, W. (1997). *The incestuous workplace: Stress and distress in the organizational family*. Center City, MN: Hazelden.

*seen as a violation of its perfection....Philosophy becomes gospel, gospel become dogma, and dogma is codified in doctrine.*²⁵³

The history of addiction treatment and recovery is strewn with the carcasses of professional and peer-based organizations that saw their own ideas and ways of knowing as the only source of truth.

A second danger is that the forces of professionalization, bureaucratization, and commercialization will usurp P-BRSS—displacing experiential knowledge with theoretical knowledge and concerns about organizational management and finance. If there is a wholesale shift in focus from people to paper, profit, and professional status, the conditions will be set to threaten the very hope and promise that this new recovery orientation holds out.²⁵⁴ AA's co-founders each faced the temptation of professionalism, but eschewed professionalizing their AA service work. After much deliberation, Bill Wilson turned down an offer to work as a lay alcoholism therapist at Charles Towns Hospital,²⁵⁵ and Dr. Robert Smith refused to charge fees for the more than 5,000 alcoholic men and women he treated medically.²⁵⁶ However, when these colonizing forces succeed, conditions are set for the rise of new movements that re-extol the value of experiential knowledge—as is now happening through the growing interest in P-BRSS.

This does not suggest that professional or recovery community organizations should not seek financial resources to pursue their respective missions. But it does suggest the importance of filtering all issues of finance through the question of whether pursuing a particular resource will enhance the mission of increasing individual, family, and community recovery capital or be a diversion from this mission.

Financial considerations can also have a negative impact on relationships with clients within the professional paradigm. Along with a rigid adherence to this paradigm, the constraints imposed by managed care and financial scarcity can lead to loss of mutual vulnerability, inequalities in power, preoccupation with papers and procedures, and distracting fixations on time spent in sessions (limited doses, days, etc.) and money. The milieu of modern addiction treatment has cooled dramatically through its maturation. P-BRSS constitute an effort to re-inject personal passion and personal involvement back into the recovery catalyst process, and their effects on support relationships have often been highly positive.

Concerns about the professionalization of P-BRSS go far beyond styles of knowing. At a practical level, professionalism in any field involves pushing

²⁵³ White, W. (1997). *The incestuous workplace: Stress and distress in the organizational family*. Center City, MN: Hazelden.

²⁵⁴ Blum, T. & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors. *Journal of Health and Social Behavior*, 26(4), 365-378. White, W. (2006a). The voice of history: Sponsorship and peer-based recovery support services. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*, Winter Issue, 7-8.

²⁵⁵ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

²⁵⁶ Was Dr. Bob the first two-hatter? (1975). *AA Grapevine*, 31(8), 14-15.

issues congruent with the financial interests and social status of the profession and protecting one's declared turf from encroachment by other professions and cultural institutions.²⁵⁷ Successful efforts at professionalization usually occur in tandem with the rise of new social institutions. Such linked events can fundamentally redefine the recovery support relationship and shift the focus of that relationship from the needs of the person to the needs of the service profession and the service institution. Those peer-based efforts that have survived over time have sustained core values and principles, such as AA's Twelve Traditions, that have helped members and the organization as a whole avoid the temptations of professional status and financial profit.

To sustain their non-professional status, recovery community organizations providing peer-based recovery support services must find a way to transcend what Robert Michels²⁵⁸ referred to as the "iron law of oligarchy"—the tendency of organizations to become less democratic, and for organizational relationships to become less egalitarian, as organizations grow in size and complexity. In Michels' view, the emerging need for efficiency, rapid decision-making, task delegation, and role specialization inevitably breeds bureaucratization, centralization of power, and relationships based on authority.

A conscious and sustained effort to avoid these tendencies and their effects on service relationships is a distinctive quality of organizations whose missions include the delivery of P-BRSS.²⁵⁹ The move to professionalize P-BRSS, driven in part by the desire for reimbursement, is being undertaken with the noblest of intentions, to improve opportunities for sustained recovery. However, if care is not taken, the essence of what distinguishes peer support from professionally directed treatment services might be destroyed. This corruption might occur within any organizations—from treatment programs to recovery community organizations—that offer P-BRSS.

There is a process through which indigenous non-professionals can lose their effectiveness by over-identifying with the professional organization that has hired them and the organization's professional values.

*In overidentifying with the agency in this way, the nonprofessional worker underidentifies with the community. He may begin to feel superior to his less fortunate fellows...This type of reaction militates against effectiveness of the nonprofessional as a communication link....Care must be taken in both selection and training to expose, and clearly oppose, this tendency.*²⁶⁰

²⁵⁷ Van Wormer, K. (1986). The sociology of alcoholism counseling: A social worker's perspective. *Journal of Sociology and Social Welfare*, 13(3), 643-656.

²⁵⁸ Michels, R. (1915). *Political parties: A sociological study of the oligarchical tendencies of modern democracy* (E. Paul & C. Paul, Trans.). New York: The Free Press.

²⁵⁹ The fellowship of Alcoholics Anonymous illustrates how this can be done via the decentralization and rotation of leadership and the codification of organizational values (e.g., Twelve Traditions) about the management of power, money, property, professional status, and public esteem.

²⁶⁰ Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

*Care might well be taken that the training...[of recovering addicts to become counselors] does not have as its objective the manufacture of junior therapists such that the counselor is led to ape the behaviors of the "professional" in uncovering and understanding client problems rather than in providing client guidance and support for undertaking new behaviors. The temptation may be large for both the counselor and trainer to make the counselor over in a traditional therapist image. In this transition, he may begin to ignore, if not downgrade, some of the advantages he brings to the counseling situation by virtue of his community and life experiences.*²⁶¹

The reverse of this process can also occur when professional models of addiction treatment are abandoned for the experience-based models of care characterized by anti-intellectualism, anti-professionalism, and a disregard for mainstream regulatory and funding structures.

The loss of either way of knowing—experiential knowledge or professional knowledge—constitutes a loss. These different ways of knowing can be highly complementary and offer valued and variable help that responds to the unique needs of individuals and families at different points in their addiction and recovery careers. The tension between these ways of knowing may also be a source of continued organizational renewal that helps professional and peer-based organizations escape Michels' iron law of oligarchy.

PRIMACY OF PERSONAL RECOVERY AND IMPORTANCE OF SELF-CARE

All peer-based recovery support services rest on the primacy of personal recovery. There are positively evaluated projects that have engaged peer leaders within illicit drug cultures to serve as peer helpers to reduce HIV transmission among injection drug users,²⁶² but studies have shown that outreach workers in recovery have greater credibility with active drug users than do those who are still using.²⁶³ AA co-founder Bill Wilson stated the operative principle here: "...you cannot transmit something you haven't got."²⁶⁴

One of the profoundly important lessons within the history of P-BRSS is that offering recovery support to others is not in itself a program of personal

²⁶¹ Brown, B. S. & Thompson, R. F. (1975). The effectiveness of formerly addicted and nonaddicted counselors on client functioning. *Drug Forum*, 5(2), 123-129.

²⁶² Latkin, C.A. (1998). Outreach in natural settings: The use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Reports*, 114, Supplement 1, p. 151-159).

²⁶³ Mitchell, S.G., Peterson, J.A. & Latkin, C.A. (2006). The impact of drug use on perceptions of credibility in indigenous outreach workers. *Qualitative Health Research*, 16(8), 1108-1119.

²⁶⁴ *Alcoholics Anonymous: The story of how more than one hundred men have recovered from alcoholism.* (1939). New York: Works Publishing Company, p. 178.

recovery.²⁶⁵ That lesson surfaces repeatedly within the early history of addiction treatment and recovery, and relapse has continued to be a concern within the modern history of addiction counseling and P-BRSS.²⁶⁶ Alcohol- or drug-related impairment continues to be among the top reasons for ethics complaints filed against addiction counselors.²⁶⁷ In response to this history, self-care is an important theme within the contemporary culture of P-BRSS—perhaps more so than within mainstream helping professions. This primacy of recovery must be sustained in the face of the P-BRSS specialist’s potential estrangement from his or her professional colleagues (via being devalued, disrespected, and underpaid) and his or her own recovery community (via criticism for “making money off the Program”).²⁶⁸ Such marginalization can pose threats to one’s sobriety, well being, and sanity.

The primacy of recovery for P-BRSS specialists goes beyond just maintaining abstinence. It encompasses the personal qualities and style of living that make long-term recovery possible, meaningful, and attractive to others. Humility and harmony are frequently cited by P-BRSS specialists as aspirational values. To sustain humility, we must avoid “Stratton’s Disease” (the grandiose delusion that we understand addiction and recovery better than anyone else)²⁶⁹ and falling in love with the image of ourselves as helpers—stances that transmit an air of superiority and benevolent condescension that repels the very people we deem to help. To sustain harmony and balance, we must regularly monitor and adjust the time and emotional resources that we allocate to self, family, community, and those seeking recovery.

²⁶⁵ White, W. (2006a). The voice of history: Sponsorship and peer-based recovery support services. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*, Winter Issue, 7-8.

²⁶⁶ Gay, G.R. & Vega, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 99-102. White, W. (1979). *Relapse as a phenomenon of staff burnout in recovering substance abusers working as counselors*. Rockville, MD: HCS, Inc. Williams, E., Collyer, J., Schaake, I., et al. (1990). Counselor wellness and impaired practice: Survey results of the Kansas Alcoholism and Drug Addiction Counselors Association. *The Counselor*, January/February, 9, 39-40.

²⁶⁷ While relapse is highlighted as a concern for people in recovery working in service roles, the addictions literature is strangely silent about the impairment of persons not identified as “in recovery”—persons whose impairment may spring from AOD-related or other problems. White, W. (2009). The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58. St. Germaine, J. (1997). Ethical practices of certified addiction counselors: A national survey of state certification boards. *Alcoholism Treatment Quarterly*, 15, 63-72.

²⁶⁸ Strachan, J.G. (1973). Non-alcoholic versus recovered personnel. In G.E. Staub & L.M. Kent (Eds.). *The para-professional in the treatment of alcoholism* (pp. 85-90). Springfield, IL: Charles C. Thomas.

²⁶⁹ Stratton, R. (1976). “Stratton’s Disease”: An ailment of alcoholologists. *Alcohol Health and Research World*, Summer, 27-28.

ROLE OF RISK IN RECOVERY

A unique foundation of P-BRS is the belief that risk is an essential part of recovery and that a life without risk and challenge is a life lived in shackles. Recovering people have the right to take risks and make mistakes, taking full responsibility for personal choices and their consequences. Most of all, they have a right to own their own successes and, at a larger level, to be part of the solution to the very problems that once defined them. The focus of P-BRS is not on preventing all risk—but in supporting people to take the kinds of risks that lead to a productive and meaningful life of recovery within the community. Embedded within the peer recovery culture is the understanding that the same “Go for it!” attitude that fueled recklessness and excess in addiction can be the source of great success and service when it is channeled into a recovery process. The latter risks often involve acts of care, purposeful self-development, and helping encounters with others.

The question of when a person in recovery is “ready” to help others is not a question of timing but a question of type and degree of help. The person with two days’ sobriety may have something of great value to offer the person struggling to get through his or her first day sober. One of the consistent threads in the history of recovery is that a most perfect and perfectly timed message can be delivered by the most imperfect of messengers.²⁷⁰ Professional paternalism, and with it preoccupation with problems, vulnerabilities, risks, and liabilities, can prevent people from taking risks and assuming helping roles. Peer recovery traditions focus instead on risk in service to recovery.²⁷¹

THE VALUE OF P-BRSS

In summary, supporters of P-BRSS argue that recovering people in paid and volunteer roles can enhance the long-term recovery of others by:

- sharing the sensitivities, knowledge, skills, and zeal for helping others that are among the fruits of their own recovery from addiction;
- using “street credibility”²⁷² to exhibit empathy, establish rapport, and engage the most alienated, difficult-to-reach individuals and families affected by alcohol and other drug problems;
- communicating with individuals seeking recovery from a foundation of shared experience and a common language;
- delivering support within a relationship that is free of contempt and marked by mutual respect and honesty;

²⁷⁰ For example, see the early history of AA in Cleveland, where requests for help came so quickly in response to a series of *Cleveland Plain Dealer* articles on AA that members with little sobriety were used to coach others through their first days of sobriety. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Healty Systems.

²⁷¹ Personal communication with Fraser Ross, January, 2009.

²⁷² Gay, G.R. & Vega, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 99-102.

- understanding and working within the cognitive and behavioral defenses of persons receiving treatment and recovery support services (minimizing cons, hustles, and manipulations);
- serving as a communication bridge between the person seeking help and other professional helpers—mediating the “patients’ cultural and subcultural values, behaviors, linguistic metaphors, nonverbal cues, and conceptual frameworks”²⁷³ with the professional culture;
- stirring and sustaining hope through personal charisma and role modeling;
- promoting the benefits of involvement in a formal program of professional treatment and/or recovery;
- linking individuals to particular support groups using the intimate knowledge they have gained through personal participation in these groups;
- linking individuals and families to professionally directed treatment and allied health and human services;
- exhibiting a high degree of commitment (“more than a job”; willingness to go “above and beyond” on behalf of those they serve);
- providing behavioral control (rule enforcement) within treatment milieus,
- giving individuals and families recovery guidance to that is pragmatic, concrete, specific, and experience-based;
- providing sober companionship (a safety net) for the person’s first entry into the community as a recovering person;
- guiding the transfer of affiliation from cultures of addiction to local communities of recovery and, when possible, to the mainstream community;
- lowering treatment dropout rates via the provision of collateral support;
- providing sustained post-treatment monitoring, stage-appropriate recovery education, recovery coaching, and, when needed, early re-intervention;
- developing and mobilizing local recovery support services; and
- creating community environments in which recovery can thrive through such activities as recovery community education, recovery advocacy, and support of recovery celebration events.²⁷⁴

²⁷³ Talbott, J. A., Ross, A. M., Skerrett, A. F., Curry, M. D., Marcus, S. I., Theodorou, H., et al. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, 130, 805-808.

²⁷⁴ Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press. Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In B. Kissin & H. Beglieter (Eds.), *The biology of alcoholism, Vol. 5, treatment and rehabilitation of the chronic alcoholic* (pp. 545-565). New York: Plenum Press. Chappel, J.N., Charnett, C.V., & Norris, T.L. (1974). Paraprofessional and professional teamwork in the treatment of drug dependence. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 297-306). Cambridge, MA: Schenkman. Cuskey, W.R. & Premkuman, R. (1973). A differential counselor role model for the treatment of drug addicts. *Health Services Reports*, 88, 663-668. Flores, V.J. & Rice, K.A. (1974). Training viewpoints on paraprofessional counselors.

CRITICISMS OF P-BRSS

Criticisms of P-BRSS, particularly challenges to the early role of the recovering “paraprofessional” counselor in the early 1970s, have included the following:

- Alcohol and drug dependencies are such complex, intractable disorders that only trained professionals are qualified to treat them; counseling by the recovering paraprofessionals “who have assumed counseling positions by obtaining pseudoprofessional credentials” might actually do harm and injury to those they seek to help.²⁷⁵
- Traditionally trained counselors who are in recovery may be ineffective in counseling those with less severe AOD problems.²⁷⁶
- The current infatuation (early 2000s) with P-BRSS is a regressive step toward the demedicalization and deprofessionalization of addiction treatment.²⁷⁷
- People seeking helping roles who have a personal recovery background should not be given preference, because recovery status is not a significant factor in counselor effectiveness as measured by client attraction, engagement, retention, or long-term recovery outcomes. (See Chapter Six.)

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- In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1048-1050). Cambridge, MA: Schenkman. Gay, G.R. & Vega, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 99-102. King, B.L., Bissell, L.C., & O'Brien, P. (1979). Alcoholics Anonymous, alcoholism counseling, and social work treatment. *Health and Social Work*, 4, 181-198. Luria, D. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, 2(2), 106-109. Mann, M. (1973). Attitude: Key to successful treatment. In G. E. Staub & L. M. Kent (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas. McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield, IL: Charles C. Thomas Publisher. Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, 24(12), 839-841. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58. Winick, C. (1990). The counselor in drug user treatment, *International Journal of the Addictions*, 25(12a), 1479-502.
- ²⁷⁵ West, P.L., Mustaine, B.L., & Wyrick, B. (2002). Apples and oranges make a nice start for a fruit salad: A response to Culbreth and Borders (1999). *Journal of Counseling and Development*, 80, 72-76.
- ²⁷⁶ Sobell, M. & Sobell, L. (1987). Conceptual issues regarding goals in the treatment of alcohol problems. *Drugs and Alcohol*, 1(2-3), 1-37.
- ²⁷⁷ On the lecture circuit, I frequently am asked by treatment representatives whether peer support programs like CSAT's Recovery Community Service Program and Access to Recovery programs are a precursor to the future de-funding of professionally directed addiction treatment.

- Similar backgrounds within a helper-helpee relationship can lead to “therapeutic scotoma” (blind spots within the helper’s visual field).²⁷⁸
- Recovering people are prone to countertransference (“biases, prejudices, and distortions” through which they force each helpee into the recovering person’s own pathway/style of recovery, repel others with an attitude of self-righteousness, or are personally wounded by the continued addiction of those they seek to help).²⁷⁹
- Some recovering people, in spite of their own recovery success, view people addicted to alcohol and/or drugs in moralistic terms and are prone to a “reverse sort of snobbery.”²⁸⁰
- Self-disclosure of one’s recovery status and story in the counseling relationship is clinically ineffective and a breach of professional ethics.²⁸¹
- Recovering people who work as professional helpers have “questionable motives” for seeking helping roles and are at increased risk of burnout and relapse.²⁸²
- Recovering people working as counselors do not maintain proper clinical documentation and are not as open to supervision as professionally trained counselors.²⁸³

One of the most consistent criticisms of the role of recovering people in the treatment field is that people in recovery inhibit the development of new knowledge and approaches to the treatment of addiction.

²⁷⁸ Shapiro, E.T. & Pinsker, H. (1973). Shared ethnic scotoma. *American Journal of Psychiatry*, 130, 1338-1341.

²⁷⁹ De Angelis, G.G. & Ross, E.A. (1978). A comparison of nonaddict and ex-addict professionals in an adolescent treatment program. *Drug and Alcohol Dependence*, 3(5), 319-329. Kaufman, E. (1978). The use of ex-addicts and other paraprofessionals as mental health workers in prison. *Diseases of the Nervous System*, 37(12), 679-682. LaRosa, J.C., Lipsius, S.H. & LaRosa, J.H. (1974). Experiences with a combination of group therapy and methadone maintenance in the treatment of heroin addiction. *International Journal of the Addictions*, 9, 605-617. Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher. Tournier referred to this process as the “homogenization of a wide diversity of drinking problems.” Tournier, R. E. (1979). Alcoholics Anonymous as treatment and as ideology. *Journal of Studies on Alcohol*, 40, 230-239.

²⁸⁰ Rivers, C. (1984). How to survive in a chemical dependency agency. In Lawson, G, Ellius, D. & Rivers, C. (Eds.). *Essentials of Chemical Dependency Counseling*, Aspen, p. 147-190.

²⁸¹ This was the rationale that many treatment programs used to prohibit their counselors from providing a factual response to questions regarding their recovery status.

²⁸² Anderson, S.C. & Wiemer, L.E. (1992). Administrators’ beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73, 596-603.

²⁸³ Siassi, I., Angle, B.P., & Alston, D.C. (1977). Who should be counselors in methadone maintenance programs: Ex-addicts or nonaddicts? *Community Mental Health Journal*, 13(2), 125-132.

...the most personal and poignant dimension may be that the ex-alcoholic is torn inside himself between a commitment to a view of alcoholism that undergirds his continuing personal stability and a commitment to intellectual and scientific knowledge and its concurrent professional integrity...he may have less personal freedom to look at alcoholism problems dispassionately and perhaps innovate new approaches.²⁸⁴

TESTING THE THEORETICAL FOUNDATIONS OF P-BRSS

The key ideas and propositions set forth in this chapter regarding P-BRSS can be viewed as hypotheses that need to be tested in empirical studies of P-BRSS and through the ongoing monitoring of recovery-focused systems-performance measures. The coming chapters summarize findings from existing studies. Examples of performance measures that can be used to test the theoretical foundations of P-BRSS are displayed in Table 7.

Table 7: Performance Measures and P-BRSS Core Ideas

Theoretical Proposition	Example of Performance Measure
Wounded Healer	- Recovery representation (measured by percentage) on governing board, executive staff, direct service staff, and volunteers - Relationship of recovery representation to recovery outcomes
Experiential Knowledge	Relationship of recovery outcomes to average number of recovering people each person is exposed to during a service episode
Mutual Identification	- Policies encouraging appropriate use of staff/volunteer disclosure of recovery status/story - Frequency of self-disclosure as a helping intervention - Evaluation of effects of helper self-disclosure on helping alliance and recovery outcomes

²⁸⁴ Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher.

Theoretical Proposition	Example of Performance Measure
Chronic Illness and Peer Support	• Average number of years/months between first service episode and achievement of first year of sustained recovery—with and without P-BRSS • Quality-of-life measures for individuals and families experiencing chronic substance use disorders—with and without P-BRSS • Percentage of persons who are admitted, retained, and assertively linked to a recommended next level of care • Percentage of persons who maintain continuity of contact within a primary recovery support relationship across levels of care
Charisma	• Percentage of service recipients who attribute early engagement to energy, enthusiasm, and influence of peer helper • Percentage of service recipients who attribute service termination to intrusiveness/paternalism/domination by peer or professional helper
Stigma/Attitudes	• Percentage of individuals receiving P-BRSS who report feeling safe and respected within the peer service relationship • Percentage of clients re-initiating service after a relapse who report being welcomed, respected, and encouraged rather than shamed • Percentage of clients discussing their personal response to the social stigma attached to AOD problems
Helper Therapy Principle	• Percentage of P-BRSS specialists who report that their personal recovery has been enhanced by their work as a P-BRSS specialist • Percentage of P-BRSS staff who have maintained uninterrupted sobriety during their tenure as peer support specialists
Respect for Calling	• Percentage of P-BRSS staff/volunteers who report feeling called to service work with individuals/families seeking recovery
Recovery Management	• Comparison of access, early retention, service dose, service scope, and post-treatment recovery support group participation rates—with and without P-BRSS • Percentage of clients who report that their motivation for recovery was sustained as a result of the peer support relationship

Theoretical Proposition	Example of Performance Measure
Ecology of Recovery	- Percentage of individuals for whom family recovery capital was evaluated - Percentage of individuals with family members involved in the recovery support process - Average number of family members per client receiving P-BRSS - Percentage of clients visited by peer/professional staff in the client's natural living environment - Percentage of individuals for whom community recovery capital was formally evaluated
Cultures of Addiction/Recovery	- Percentage of clients for whom degree of enmeshment in culture of addiction was evaluated - Percentage of clients who were assertively linked to indigenous communities of recovery
Primacy of Recovery	- Percentage of P-BRSS specialists involved in weekly personal recovery support activities - Annual lapse/relapse rate of P-BRSS specialists (staff and volunteers)
Dangers of Professionalism and Anti-Professionalism	Percentage of P-BRSS programs that retain P-BRSS service mission and maintain fidelity to core service values
Continuity of Support	- Percentage of individuals who are admitted and retained within a next level of recommended care (connection as a percentage of assertive linkage attempts). - Percentage of individuals involved in two or more levels of care who report continuity of contact through a single P-BRSS relationship across levels of care
Minimization of Harm	- Number of complaints alleging harm filed by individuals/families receiving P-BRSS - Percentage of clients who experience measurable deterioration in health and functioning during the service process
Stewardship/Cost Effectiveness	- Evaluation of cost offsets resulting from shortened addiction careers (reduced readmissions, reduced health care costs, reduced incarceration rates) - Cost-benefit analysis for the P-BRSS infrastructure and service delivery

Table 7 illustrates that many of the constructs that underlie P-BRSS could be tested in formal scientific studies and through simple, program-level monitoring processes. The next chapter begins our exploration of what scientific studies have revealed to-date about peer-based recovery support.

Chapter Four

Scientific Evaluation of Peer-based Support: Studies of the Effects of Participation in Recovery Mutual-aid Societies

SUMMARY OF KEY FINDINGS

- Scientific studies regarding the effects of participation in recovery mutual-aid societies on long-term recovery outcomes are limited in scope and methodological rigor.
- Most of what is known about mutual-aid and recovery outcomes is based on studies of the effects of involvement in Alcoholics Anonymous by individuals treated in professionally directed addiction treatment programs.
- Participation in recovery mutual-aid societies typically enhances long-term recovery rates, elevates global functioning, and reduces post-recovery costs to society among diverse demographic and clinical populations.
- Individual responses to recovery mutual-aid groups are variable, including those who respond optimally, those who respond partially, and those who fail to respond.
- Recovery mutual aid participation has multiple active ingredients, including motivational enhancement for recovery, reconstruction of personal identity, reconstruction of family and social relationships, enhanced coping skills, and the personal effects of helping others.
- The effects of recovery mutual aid involvement are interdependent with frequency, intensity, and duration of involvement.
- Combining recovery mutual aid and professionally directed addiction treatment has additive effects in clinical populations.
- For clients in addiction treatment, affiliation with and benefits from recovery mutual-aid societies are influenced by counselor attitudes toward mutual aid, the style of linkage (assertive vs. passive, degree of choice, and personal matching), and the timing of linkage (during treatment vs. following treatment).
- The Internet may provide an effective adjunctive or alternative delivery device for peer-based recovery support services, but studies of Internet-based recovery support services are at an early stage.

- The potential positive effects of recovery mutual-aid participation are often not achieved due to weak linkage procedures and high early dropout rates.

There is a substantial body of research literature confirming the role of social support, particularly recovery-specific social support, on the long-term resolution of severe alcohol- and other-drug problems.²⁸⁵ Put simply, the odds of recovery rise in tandem with social network support for abstinence and decline with the increased density of heavy AOD users in one's social network.²⁸⁶ The presence or absence of family and peer support for abstinence exerts a particularly powerful influence on the recovery outcomes of adolescents treated for substance use disorders.²⁸⁷ In this and proceeding chapters, we will explore how different types of peer support influence the prospects of long-term recovery.

In spite of the long history of organized peer support in addiction recovery, scientific studies of the effects of peer support on long-term recovery are limited in scope and methodological rigor. Studies to-date fall into three general topical categories, which we will address in this and coming chapters: 1) the effects of participation in recovery mutual-aid societies, 2) the effects of participation in other recovery community support institutions, and 3) studies of recovering people working in multiple service roles in addiction treatment and allied health organizations.

As noted earlier, there are numerous limitations that prevent drawing definitive conclusions on critical questions related to the design and delivery of peer-based recovery support. These limitations include questions toward which no studies have been directed and studies that suffer from small sample sizes, non-representative samples, selection bias, lack of control groups, lack of randomization, and reliance on self-report without biomedical or collateral corroboration of abstinence. Studies to-date are also limited by their primary focus on one recovery mutual-aid framework (Alcoholics Anonymous), AA-

²⁸⁵ Beattie, M.C. & Longabaugh, R. (1999). General and alcohol-specific social support following treatment. *Addictive Behaviors*, 24, 593-606. Groh, D.R., Jason, L.A., Davis, M.I., Olson, B.D., & Farrari, J.R. (2007). Friends, family, and alcohol abuse: An examination of general and alcohol-specific social support. *The American Journal on Addictions*, 16, 49-55.

Longabaugh, R., Wirtz, P.W., Zweben, A. & Stout, R.L. (1998). Network support for drinking. Alcoholics Anonymous and long-term matching efforts. *Addiction*, 93, 1313-1333.

²⁸⁶ Bond, J., Kaskutas, L.A., & Weisner, C. (2003). The persistent influence of social networks and Alcoholics Anonymous on abstinence. *Journal of Studies on Alcohol*, 64(4), 579-588.

Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, 31(6), 585-612. Zywiak, W., Longabaugh, R., & Wirtz, P.W. (2002). Decomposing the relationships between permanent social network characteristics and alcohol outcome. *Journal of Studies on Alcohol*, 63, 114-121.

Mohr, C., Averna, S., Kenny, D., & Del Boca, F. (2001). "Getting by (or getting high) with a little help from my friends": An examination of adult alcoholics' friendships. *Journal of Studies on Alcohol*, 62(5), 637-645. Weisner, C., Matzger, H., & Kaskutas, L. A. (2003). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. *Addiction*, 98(7), 901-911.

²⁸⁷ Godley, M.D. & Godley, S.H. (in press). Continuing care following residential treatment: History, current practice, and emerging approaches. In N. Jainchill (Ed.), *Understanding and treating adolescent substance use disorders*. Kingston, New Jersey: Civic Research Institute.

influenced treatment models, and treatment population responses to AA during the earliest stages of recovery.²⁸⁸ Most studies of people in recovery working as addiction counselors are limited by having been conducted in an era in which most addiction counselors working in addiction treatment possessed neither significant education or training—a status that has changed dramatically over the past 40 years.

The discussions in the coming chapters highlight studies that shed light on P-BRSS and discuss critical issues related to P-BRSS that deserve further scientific investigation. As we proceed, it would be best if the reader considered the findings presented as “true” of some people in some places at a particular point in time. The collective findings of the studies reviewed tell a story, but it is not the whole story.

LIMITED SCOPE OF RESEARCH ON RECOVERY MUTUAL-AID SOCIETIES

Most of what we know scientifically about the effects of participation in addiction recovery mutual-aid societies on long-term recovery outcomes is based on studies of adult members of Alcoholics Anonymous (AA) and, to a lesser extent, Narcotics Anonymous (NA).²⁸⁹ Early studies of AA suffered from weak methodological rigor, which limited the value of their findings,²⁹⁰ but the quality of AA studies has improved markedly in the past decade.²⁹¹ In spite of these improvements, there is still great controversy surrounding AA research and the wildly divergent conclusions drawn from that research. (See Kaskutas, in press, for the latest review.)²⁹²

Studies of alternative recovery mutual-aid societies have begun to appear in addiction science journals, but these early reports are primarily descriptive and do not reflect long-term recovery outcome studies. This literature includes papers on new 12-Step programs for drug dependencies other than alcohol and

²⁸⁸ Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, 57(1), 65-72.

²⁸⁹ Brown, B.S., O’Grady, K.E., Farrell, E.V., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, 27(1), 147-160. Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, UK: Cambridge University Press.

²⁹⁰ Emrick, C. D., Tonigan, J. S., Montgomery, H., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. McCrady & W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 41-78). Piscataway, NJ: Rutgers Center for Alcohol Studies. Kownascki, R.J. & Shadish, W.R. (1999). Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments. *Substance Use and Misuse*, 34(13), 1897-1916. Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, 57(1), 65-72.

²⁹¹ Humphreys, K. (2006). The trial of Alcoholics Anonymous. *Addiction*, 101, 617-618.

²⁹² Kaskutas, L.A. (in press). Alcoholism Anonymous effectiveness: Faith meets science. *Journal of Addictive Diseases*.

narcotics,²⁹³ Women for Sobriety,²⁹⁴ Secular Organizations for Sobriety,²⁹⁵ Rational Recovery,²⁹⁶ LifeRing Secular Recovery,²⁹⁷ SMART Recovery®,²⁹⁸ and Moderation Management.²⁹⁹ Particularly striking is the lack of scientific literature—even descriptive studies—on faith-based addiction recovery support groups.

There are multiple methodological challenges in studying mutual-aid recovery support groups, but perhaps the most significant is that “the more the researcher controls the group for research purposes, the less what is being evaluated is truly a self-help group as opposed to a professionally controlled paraprofessional helping program.”³⁰⁰ Recent enhancements in the methodological quality of studies of recovery support groups (for example,

²⁹³ Donovan, D.M. & Wells, E.A. (2007). “Tweaking 12-Step”: The potential role of 12-Step self-help group involvement in methamphetamine recovery. *Addiction*, 102(Suppl. 1), 121-129. Weiss, R.D., Griffin, M.L., Gallop, R., Onken, L.S., Gastfriend, D.R., Daley, D., et al. (2000). Self-help group attendance and participation among cocaine-dependent patients. *Drug and Alcohol Dependence*, 77, 177-84.

²⁹⁴ Kaskutas, L. (1992). Beliefs on the sources of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems*, Winter, 631-648. Kaskutas, L. (1994). What do women want out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 11(3), 185-195.

²⁹⁵ Connors, G.J. & Dermen, K.H. (1996). Characteristics of participants in Secular Organization for Sobriety. *American Journal of Alcohol and Drug Abuse*, 19(4), 281-295.

²⁹⁶ Rational Recovery (RR) is listed here as a mutual recovery support group because it served that function during its early history, spreading to more than 700 cities in the United States. Jack Trimpey, the founder of RR, later abandoned the use of groups, and a split within RR in 1994 led to the creation of SMART Recovery, which does continue to function as a recovery mutual-aid society with local group meetings. Today, Rational Recovery Systems, Inc. is a for-profit organization that promotes self-recovery through the use of the addictive voice recognition technique (AVRT). Ellis, A. (1992). Rational Recovery and the addiction to 12-Step therapies. *Humanist*, 52(6), 33-35. Galanter, M., Egelko, S., & Edwards, H. (1993). Rational Recovery: Alternative to AA for addiction? *The American Journal of Drug and Alcohol Abuse*, 19(4), 499-510. Schmidt, E. (1996). Rational Recovery: Finding an alternative for addiction treatment. *Alcoholism Treatment Quarterly*, 14(4), 47-57. Schmidt, E.A., Carns, A., & Chandler, C. (2001). Assessing the efficacy of Rational Recovery in the treatment of alcohol/drug dependency. *Alcoholism Treatment Quarterly*, 19(1), 97-106.

²⁹⁷ White, W. & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, 6(4), 58-61.

²⁹⁸ Horvath, A. (1999-2000). SMART Recovery. *International Journal of Self Help and Self Care*, 1(2), 163-169.

²⁹⁹ Humphreys, K. (2003). Alcohol & drug abuse: A research-based analysis of the moderation management controversy. *Psychiatric Services*, 54, 621-622. Humphreys, K. & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol*, 62(4), 528-532. Klaw, E. & Humphreys, K. (2000). Life stories of Moderation Management mutual help group members. *Contemporary Drug Problems*, 27, 779-803. Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy*, 17, 295-303.

³⁰⁰ Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

improved measurement, longer follow-up periods, higher follow-up rates, and the use of comparison groups) are generating replicated findings that allow the articulation of preliminary conclusions related to the operation and effectiveness of such groups, particularly Alcoholics Anonymous.³⁰¹ The extent to which findings from AA can be generalized to other recovery support societies is unclear.

ROLE OF MUTUAL AID IN RECOVERY OUTCOMES

Participation in addiction recovery support groups typically enhances long-term recovery outcomes.³⁰² Recovery support group participation is also linked to increased global (physical, emotional, relational, occupational) health and functioning,³⁰³ as well as reduced mortality rates,³⁰⁴ particularly rates of suicide.³⁰⁵

³⁰¹ Kelly J. F. & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J. R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

³⁰² Emrick, C. D., Tonigan, J. S., Montgomery, H., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. McCrady & W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 41-78). Piscataway, NJ: Rutgers Center for Alcohol Studies. Fiorentine, R. (1999). After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, 25(1), 93-116. Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B. et al., (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 151-158. Kisson, W., McLeod, C., & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, 26, 311-23. McKellar, J., Stewart, E., & Humphreys, K. (2003). Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequences, or just a correlate? A prospective 2-year study of 2,319 alcohol-dependent men. *Journal of Consulting and Clinical Psychology*, 71(2), 302-308. Morgenstern, J., Bux, D.A., Jr., Labouvie, E., Morgan, T., Blanchard, K.A., & Muench, F. (2003). Examining mechanisms of action in 12-Step community outpatient treatment. *Drug and Alcohol Dependence*, 72, 237-247. Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768-777. Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, 60(4), 437-447. Vaillant, G.E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, 98, 1043-1051.

³⁰³ Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, UK: Cambridge University Press.

³⁰⁴ Cuupers, P., Riper, H., & Lemmers, L. (2004). The effects of brief interventions for problem drinking: A meta-analysis. *Addiction*, 99, 839-845. Timko, C., DeBenedetti, A., Moos, B.S., & Moos, R.H. (2006). Predictors of 16-year mortality among individuals initiating help-seeking for an alcoholic use disorder. *Alcoholism: Clinical and Experimental Research*, 30(10), 1711-1720.

³⁰⁵ Mann, R.E., Zalcman R., Smart, R., Rush, B.R., & Suurvali, H. (2006). Alcohol consumption, Alcoholics Anonymous membership, and suicide mortality rates, Ontario, 1968-1991. *Journal of Studies on Alcohol*, 67, 445-453.

In 1977, Emrick, Larsen, and Edwards identified three principles related to AA and professional treatment involvement and drinking outcomes, principles that have stood the test of time: 1) *AA is more effective than professional treatment in helping alcoholics maintain total abstinence*, 2) *professional treatment appears to be more effective than AA in helping alcoholics reduce drinking without becoming totally abstinent*, and 3) *both peer and professional helpers appear to be needed, because each is helpful only to some people*.³⁰⁶

But how much benefit can one expect from AA participation? Humphreys and Kaskutas recently reviewed the latest research studies on such effects and drew the following conclusions:

*These studies show that among patients who receive treatment, supplemental involvement in 12-Step mutual help organizations has quite large benefits, increasing abstinence rates by 25-100%. The health care cost reductions, on the order of thousands of dollars per patient, are also of note. Importantly, these findings are not due to self-selection, they derive from randomized trials and quasi-experimental studies, and if anything, the randomized trials show greater not lesser benefits to AA/NA participation than do uncontrolled studies....What about an addicted person who is not in treatment—how much will they benefit? This is a hard question to answer, but one useful source of data is Moos and colleagues' series of studies of individuals seeking help for alcohol problems for the first time. One study in this research program compared 135 individuals who went to AA first with 66 broadly comparable people who chose to go to professional outpatient treatment. By three year follow-up, both groups had decreased their ethanol consumption and alcohol dependence symptoms by about 70%. Most of the individuals who started in AA stayed in AA and did not subsequently enter professional treatment, which suggests that large benefits of AA participation are not limited to individuals who combine treatment with mutual help group involvement.*³⁰⁷

Data from the 2006 and 2007 National Survey on Drug Use and Health reveal that approximately 5 million people a year (2% of the population over age 12) attend recovery support groups to support their recovery from alcohol and other drug-related problems. These individuals represent a high degree of

³⁰⁶ Emrick, C.D., Lassen, C.L., & Edwards, M.T. (1977). Nonprofessional peers as therapeutic agents. In A.S. Gurman & A.M. Rasin (Eds.), *Effective psychotherapy: A handbook of research* (2nd edition, pp. 120-161). Elmsford: Pergamon. Elal-Lawrence, G. Slade, P.D., & Dewey, M.E. (1986). Predictors of outcome type in treated problem drinkers. *Journal of Studies on Alcohol*, 47, 41-47. Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-Step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, 8(1), 45-59. Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, 58, 7-29.

³⁰⁷ Humphreys, K. & Kaskutas, L.A. (2007). Continuity of care guidelines for participation in mutual help organizations before, during and after addiction treatment. Presented at the 2nd Consensus Conference of the Betty Ford Institute, October 3-4, 2007.

diversity by gender, age, race/ethnicity, size of community, and family income. Of those attending recovery support groups in the past year in the U.S., 45.3% attended to resolve alcohol problems, 21.8% to resolve an illicit drug problem, and 33% to resolve problems related to both alcohol and illicit drug use. Of those reporting past-year attendance, 45.1% reported abstinence in the past month, and 54.9% reported continued substance use.³⁰⁸

VARIABILITY OF RESPONSE

The response to addiction recovery mutual-aid groups is not uniform.³⁰⁹ People exposed to a particular recovery support group may respond fully, partially, or not at all.³¹⁰ For example, in a study of client referrals to AA during treatment, 31% had an optimal response, 43% a partial response, and 22% a non-response, with the non-responders having the worst post-treatment recovery outcomes.³¹¹ Some studies have linked higher levels of AA affiliation with higher levels of problem severity among adults³¹² and adolescents.³¹³ Brown, O'Grady, Farrell, and colleagues³¹⁴ studied recovery support group affiliation patterns of clients in outpatient drug treatment who had been referred from the criminal justice system. Higher participation rates were related to greater problem severity (as measured by prior treatment and greater criminal involvement) and earlier age of onset of alcohol use.

Patterns of affiliation differ widely among those who do affiliate with recovery mutual-aid groups. Kaskutas and colleagues³¹⁵ described four such

³⁰⁸ Office of Applied Studies (2008) Participation in self-help groups for alcohol and illicit drug use: 2006 and 2007. *The NSDUH Report*, November 13, Substance Abuse and Mental Health Services Administration.

³⁰⁹ Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, 57(1), 65-72.

³¹⁰ Caldwell, P.E. & Cutter, H.S. (1998). Alcoholics Anonymous affiliation during early recovery. *Journal of Substance Abuse Treatment*, 15, 221-28. Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-Step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, 8(1), 45-59.

³¹¹ Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-Step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, 8(1), 45-59.

³¹² Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., et al. (2002). AA participation 10 years after Project MATCH treatment: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, 26(Supplement), 42A. Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, 57(1), 65-72.

³¹³ Kelly, J.F., Myers, M.G., & Brown, S.A. (2002). Do adolescents affiliate with 12-Step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63, 293-304.

³¹⁴ Brown, B.S., O'Grady, K.E., Farrell, E.V., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, 27(1), 147-160.

³¹⁵ Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, 29(11), 1983-1990.

patterns: 1) low AA attendance (participation in only a small number of meetings during first year following treatment, 2) medium AA attendance (attending a high number of meetings but only for a short period of time), 3) high attendance (increasing level of involvement during the first five years), and 4) moderate but steady attendance. They found abstinence rates increasing and decreasing in tandem with increased and decreased meeting attendance, but also documented the potential of sustained sobriety for some people following cessation of regular AA meeting attendance. They referred to this latter pattern as “positive disengagement.”³¹⁶

The growing varieties of recovery support groups and the variability of personal responses to each group suggests the use of a philosophy of choice, through which addiction professionals and peer support specialists review recovery support options with each person to achieve the best person-group match.³¹⁷ Individuals may initiate and sustain recovery within a single recovery support group, concurrently participate in more than one recovery support group, or initiate recovery through one framework and then shift to another framework to maintain that recovery. The latter is illustrated by African American women shifting from AA/NA for recovery initiation to the church as their primary source of support for recovery maintenance.³¹⁸ Although at a philosophical level some recovery support groups appear opposed to one another, at the individual level, it is common to see people simultaneously attending “opposing” mutual-aid groups such as Women for Sobriety and AA.³¹⁹

EFFECTIVENESS ACROSS DIVERSE POPULATIONS

Recent studies confirm that affiliation and recovery rates within AA also extend to:

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- ³¹⁶ Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, 29(11), 1983-1990.
- ³¹⁷ White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.
- White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51. White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor*, 9(1), 38-43.
- ³¹⁸ Kaskutas, L. (1992). Beliefs on the sources of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems, Winter*, 631-648.
- Kaskutas, L. (1994). What do women want out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 11(3), 185-195; Kelly, J.F. & Yeterian, J.D. (2008). Mutual-help groups for Dually-Diagnosed Individuals: Rationale, Description, and Review of the Evidence, *Journal of Groups in Addiction and Recovery*, 3, 3/4, 217-242. White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.
- ³¹⁹ Kaskutas, L. (1992). Beliefs on the sources of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems, Winter*, p. 631-648.

- people dependent upon drugs other than, and in addition to, alcohol;³²⁰
- adolescent and adult women;³²¹
- people of color;³²²
- young people;³²³
- people with co-occurring psychiatric disorders;³²⁴ and

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- ³²⁰ Fiorentine, R. (1999). After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, 25(1), 93-116. Siegal, H.A., Li, L., & Rapp, R.C. (2001). Abstinence trajectories among treated crack cocaine users. *Addictive Behaviors*, 26, 1-13. Weiss, R.D., Griffin, M.L., Gallop, R., Onken, L.S., Gastfriend, D.R., Daley, D., et al. (2000). Self-help group attendance and participation among cocaine-dependent patients. *Drug and Alcohol Dependence*, 77, 177-84. Witbrodt, J. & Kaskutas, L.A. (2005). Does diagnosis matter? Differential effects of 12-Step participation and social networks on abstinence. *The American Journal of Drug and Alcohol Abuse*, 31, 685-707.
- ³²¹ Hillhouse, M.P. & Fiorentine, R. (2001). 12-Step program participation and effectiveness: Do gender and ethnic differences exist? *Journal of Drug Issues*, 31(3), 767-780. Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, 32(8), 1-11. Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research*, 30(8), 1381-1392. Sanders, J.M. (2006). Women and the twelve steps of Alcoholics Anonymous: A gendered narrative. *Alcoholism Treatment Quarterly*, 24(3), 3-29.
- ³²² Caetano, R. (1993). 1993 Ethnic minority groups and Alcoholics Anonymous: A review. In B. McCrady & W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 209-231). New Brunswick, NJ: Rutgers Center of Alcohol Studies. Humphreys, K., Mavis, B. E., & Stöffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, 11, 165-180. Humphreys, K., Mavis, B. & Stoffelmayr, B. (1991). Factors predicting attendance at self-help groups after substance abuse treatment: Preliminary findings. *Journal of Consulting and Clinical Psychology*, 59(4), 591-593.
- ³²³ Hsieh, S., Hoffman, N.G., & Hollister, D.C. (1998). The relationship between pre-, during-, post-treatment factors, and adolescent substance abuse behaviors. *Addictive Behaviors*, 23(4), 477-488. Hohman, L., LeCroy, C.W., & Winston, C. (1996). Predictors of adolescent AA affiliation. *Adolescence*, 31(122), 339-352. Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, 14, 376-389. Kelly, J.F., Myers, M.G., & Rodolico, J. (2008). What do adolescents exposed to Alcoholics Anonymous think about 12-Step groups? *Substance Abuse*, 29(2), 53-72. Brown, S.A. & Ramo, D.E. (2006). Clinical course of youth following treatment for alcohol and drug problems. In H.A. Liddle & C.L. Rowe (Eds.), *Adolescent substance abuse: Research and clinical advances* (pp. 79-103). Cambridge, NY: Cambridge University Press. Tonigan, J.S., Connors, G.J., & Miller, W.R. (1998). Special populations in Alcoholics Anonymous. *Alcohol Health and Research World*, 22(4), 281-285.
- ³²⁴ Bogenschutz, M.P. & Akins, S.J. (2000). 12-Step participation and attitudes toward 12-Step meetings in dual diagnosis patients. *Alcoholism Treatment Quarterly*, 18(4), 31-45. Chi, F.W., Satre, D.D., & Weisner, C. (2006). Chemical dependency patients with cooccurring psychiatric diagnoses: Service patterns and 1-year outcomes. *Alcoholism: Clinical and Experimental Research*, 30(5), 851-859. Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R.

- people without religious or spiritual orientation.³²⁵

These findings confirm that AA has matured beyond its origins as a program for white, middle-aged, middle-class Protestant men. Studies have actually found that women participate more and benefit more from 12-Step recovery support groups following treatment than do men.³²⁶ Similarly, studies of AA and/or NA participation following treatment show that African Americans are more likely than Caucasians to participate in AA and/or NA following treatment.³²⁷

The most recent evidence available on representation of women, people of color, and young people, as revealed in available recovery fellowship membership surveys, is displayed in Table 8. Degree of diversity in social class is reflected in a combination of three factors variably reported in the membership surveys: education, employment, and income.

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- (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research*, 30(8), 1381-1392.
- Laudet, A., Magura, S., Vogel, H.S., & Knight, E. (2000). Addiction services: Support, mutual aid and recovery from dual diagnosis. *Community Mental Health Journal*, 36(5), 457-476.
- Ouimette, P., Humphreys, K., Moos, R.H., Finney, J.W., Cronkite, R., & Federman, B. (2001). Self-help group participation among substance use disorder patients with posttraumatic stress disorder. *Journal of Substance Abuse Treatment*, 20(1), 25-32.
- Rychtarik, R.G., Connors, G.J., Dermen, K.H., & Stasiewics, P.R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, 61, 134-138.
- Swift, R.M., Duncan, D., Nirenberg, T., & Femino, J. (1998). Alcoholic patients' experience and attitudes on pharmacotherapy for alcoholism. *Journal of Addictive Diseases*, 17, 35-47.
- Timko, C. & Sempel, J.M. (2004). Intensity of acute services, self-help attendance and one-year outcomes among dual diagnosis patients. *Journal of Studies on Alcohol*, 65, 274-282.
- Tonigan, J.S. & Kelley, J.F. (2004). Beliefs about AA and the use of medications: A comparison of three groups of AA-exposed alcohol dependent persons. *Alcoholism Treatment Quarterly*, 22(2), 67-78.
- ³²⁵ Brown, B.S., O'Grady, K.E., Farrell, E.V., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, 27(1), 147-160.
- Connors, G.J., Tonigan, S., & Miller, W. (2001). *Religiosity and responsiveness to alcoholism treatments*. Bethesda, MD: Department of Health and Human Services.
- Winzelberg, A. & Humphreys, K. (1999). Should patients' religiosity influence clinicians' referral to 12-Step self-help groups? Evidence from a study of 3018 male substance abuse patients. *Journal of Counseling and Clinical Psychology*, 67(5), 790-794.
- ³²⁶ Del-Boca, F.K. & Mattson, M. E..(2002). The gender matching hypothesis. In: Project MATCH hypotheses: Results and causal chain analyses, R. Longabaugh & P.W. Wirtz (Eds.). USHHS, Rockville, MD.
- Moos, R.H., Moos, B.S., & Timko, C. (2006). Gender, treatment and self-help in remission from alcohol use disorders. *Clinical Medicine & Research*, 4(3), 163-74.
- Grella, C.E., Scott, C.K., & Foss, M.A. (2005). Gender differences in long-term drug treatment outcomes in Chicago PETS. *Journal of Substance Abuse Treatment*, 28, S3-S12.
- Timko, C., Moos, R.H., Finney, J.W., & Connell, E.G. (2002). Gender differences in help-utilization and the 8-year course of alcohol abuse. *Addiction*, 97, 877-889.
- ³²⁷ Harris, A.H.S., McKellar, J.D., Moos, R.H., Schaefer, J.A., & Cronkite, R.C. (2006). Predictors of engagement in continuing care. *Drug & Alcohol Dependence*, 84, 93-101.
- Humphreys, K., Mavis, B. E., & Stöffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, 11, 165-180.

Table 8: Demographic Characteristics of Recovery Mutual-aid Societies

Membership Characteristics	AA ³²⁸ (2007)	NA ³²⁹ (2007)	CA ³³⁰ (2007)	SOS ³³¹ (1992)	WFS ³³² (1992a.b)	LSR ³³³ (2005)	MM ³³⁴ (2004)
Male	67%	55%	65%	73.4%	0%	58%	44%
Female	33%	45%	35%	36.6%	100%	42%	66%
Caucasian	85.1%	70%	68%	99.4%	98%	77%	98%
African American	5.7%	11%	19%	*	1%	5%	*
Hispanic	4.8%	11%	6%	*	0%	4%	*
Asian American	2.8%		1%	*	0%	1%	*
Native American	1.6%		5%	*	0%	1%	*
Other (or no answer)		8%	1%	.6%	0%	12%	2%
Youth representation (under age 21)	2.3%	3%	1% under 18; 8% 18-24	0%	* Average membership age is 46	Less than 1%	% under 21 not available; Mean age of 44 years

³²⁸ Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

³²⁹ Narcotics Anonymous (2008). *Information about NA*. Retrieved August 29, 2008 from <http://www.na.org/basic.htm>.

³³⁰ Cocaine Anonymous (2007). *Cocaine Anonymous Public Information Fact File: Results from the 2007 survey*. Los Angeles: CA: Cocaine Anonymous World Services Office, Inc.

³³¹ Connors, G.J. & Dermen, K.H. (1996). Characteristics of participants in Secular Organization for Sobriety. *American Journal of Alcohol and Drug Abuse*, 19(4), 281-295.

³³² Kaskutas, L.A. (1992). *Women for Sobriety: Doctoral dissertation*, School of Public Health, University of California, Berkeley.

³³³ LifeRing Secular Recovery (2008). *2005 LifeRing Participant Survey: Results*. Retrieved October 7, 2008 from http://www.unhooked.com/survey/2005_lifering_participant_survey.htm.

³³⁴ Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy*, 17, 295–303.

Membership Characteristics	AA ³³⁵ (2007)	NA ³³⁶ (2007)	CA ³³⁷ (2007)	SOS ³³⁸ (1992)	WFS ³³⁹ (1992a.b)	LSR ³⁴⁰ (2005)	MM ³⁴¹ (2004)
Education (% with at least one year of college)	*	*	50%	79.5%	66%	78%	94%
Employment	*	79%	*	62.2%	*	*	80%
Average Annual Income	*	*	*	\$31,000	\$23,000	*	76% \$50,000+

* Data not available in latest published survey

These surveys suggest that the representation of women in AA parallels the 3:1 male/female alcohol problem ratio found in the general population³⁴² and that representation of women is even higher in other recovery mutual-aid groups. People of color, particularly African Americans and Hispanics, increasingly participate in AA and NA, but there is a marked need for studies on their degree of participation in non-12-Step recovery support groups, particularly faith-based recovery support groups. Social class is not collected in AA and NA surveys, but data from other secular groups suggest that these alternatives may attract a greater proportion of people from higher educational and income levels.

As noted earlier, many people with co-occurring psychiatric and substance use disorders actively and successfully participate in mainstream recovery support meetings. Such affiliation is less likely for those with the most severe of these disorders (psychosis), and those who attend do face special issues within and obstacles to their recovery.³⁴³ These unique needs have

³³⁵ Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

³³⁶ Narcotics Anonymous (2008). *Information about NA*. Retrieved August 29, 2008 from <http://www.na.org/basic.htm>.

³³⁷ Cocaine Anonymous (2007). *Cocaine Anonymous Public Information Fact File: Results from the 2007 survey*. Los Angeles: CA: Cocaine Anonymous World Services Office, Inc.

³³⁸ Connors, G.J. & Dermen, K.H. (1996). Characteristics of participants in Secular Organization for Sobriety. *American Journal of Alcohol and Drug Abuse*, 19(4), 281-295.

³³⁹ Kaskutas, L.A. (1992). *Women for Sobriety: Doctoral dissertation*, School of Public Health, University of California, Berkeley.

³⁴⁰ LifeRing Secular Recovery (2008). *2005 LifeRing Participant Survey: Results*. Retrieved October 7, 2008 from http://www.unhooked.com/survey/2005_lifering_participant_survey.htm.

³⁴¹ Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy*, 17, 295-303.

³⁴² NIAAA (1990). *Alcohol and Health. 7th Special Report to the U.S. Congress*. Washington, DC: U.S. Government Printing Office.

³⁴³ Bogenschutz, M.P. & Akins, S.J. (2000). 12-Step participation and attitudes toward 12-Step meetings in dual diagnosis patients. *Alcoholism Treatment Quarterly*, 18(4), 31-45. Kelly, J.F. McKellar, J.D. & Moos, R. (2003). Major Depression in Patients with Substance Use

spawned three specialty recovery support groups: Dual Recovery Anonymous (DRA), Dual Disorders Anonymous (DDA), and Double Trouble in Recovery (DTR). DTR has been subjected to the most rigorous research.

DTR members in New York City report a broad spectrum of past drugs used (alcohol, marijuana, cocaine, non-prescribed pills, crack, heroin, and other drugs in order of prevalence) and a broad spectrum of past psychiatric diagnoses (unipolar depression, schizophrenia, bipolar disorder, anxiety disorder/phobia, and post-traumatic stress disorder, in order of prevalence). More than half of DTR members have multiple prior psychiatric diagnoses, and the majority have prior substance use and psychiatric treatment. Past-year substance use is very low among DTR members—from 2-10% across drug choices. Seventy-six percent of DTR members currently take medications for the management of psychiatric illness, 73% of members have attended DTR for more than a year, and 90% attend at least one DTR meeting a week.³⁴⁴

Several factors are associated with positive outcomes in DTR: enhanced internal locus of control and sociability are linked to DTR affiliation; and helper therapy (sponsoring others), reciprocal learning (mutual sharing of “experience, strength and hope”), spirituality, and hope are linked to sustained alcohol/drug abstinence and other health-promoting behaviors.³⁴⁵ The effects of DTR participation in these studies must be viewed in light of the finding that three-quarters of DTR members also attend traditional (AA/NA) 12-Step groups.³⁴⁶

COST-EFFECTIVENESS

Studies of participation in recovery support groups following addiction treatment have concluded that such participation reduces continuing care costs³⁴⁷ and post-treatment health care costs.³⁴⁸ Related to such cost reductions are the facts that AA and other recovery support groups are geographically accessible (particularly true of AA and NA), are available on a 24-hour basis

Disorders: Relationship to 12-Step self-help involvement and substance use outcomes. *Addiction*, 98, 4, 499-508.

³⁴⁴ Vogel, H.S., Knight, E., Laudet, A.B., & Magura, S. (1998). Double trouble in recovery: Self-help for people with dual diagnoses. *Psychiatric Rehabilitation Journal*, 21(4), 356-364.

³⁴⁵ Magura, S., Knight, E., Vogel, H.S., Mahmood, D., Laudt, A.B., & Rosenblum, A. (2003). Mediators of effectiveness in dual-focus self-help groups. *American Journal of Drug and Alcohol Abuse*, 29(2), 301-322. Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., Vogel, H.S., & Knight, E.L. (2003). Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors*, 28, 399-413.

³⁴⁶ Magura, S. (2008). Effectiveness of dual focus mutual aid for co-occurring substance use and mental health disorders: A review and synthesis of the “Double Trouble” in Recovery evaluation. *Substance Use and Misuse*, 43(12), 1904-1926.

³⁴⁷ Humphreys, K. & Moos, R.H. (2001). Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care: A quasi-experimental study. *Alcoholism: Clinical and Experimental Research*, 25, 711-6.

³⁴⁸ Humphreys, K. & Moos, R.H. (1996). Reduced substance-related health care costs among voluntary participants in Alcoholics Anonymous. *Psychiatric Services*, 47(7), 709-713.

without cost, and do not require time away from work.³⁴⁹

Studies of recovery mutual-aid participation by people with co-occurring substance use and psychiatric disorders show that such participation enhances medication compliance and reduces the incidence and cost of hospitalization.³⁵⁰ Humphreys and Moos³⁵¹ sum up the work to-date:

Certain tasks supportive of recovery, such as encouragement, social activities, friendship, monitoring and spiritual support, can probably be accomplished by peer-based services as well as they can by health care professionals, and at greatly reduced cost. This has a 2-fold benefit: greater likelihood of long-term recovery for the addicted individual and greater targeting of scarce professional resources to those patients who require such assistance....self-help group involvement is a useful method of extending the benefits of treatment while lowering its ongoing costs.

THE QUESTION OF HARM (IATROGENESIS)

Harm done in the name of help is a pervasive theme in the history of addiction treatment and recovery.³⁵² It is thus appropriate to raise the question whether any aspects of recovery support group participation can result in harm. Allegations of such injury have primarily targeted AA, through a series of books,³⁵³ articles,³⁵⁴ and anti-AA web sites.³⁵⁵

³⁴⁹ Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research*, 30(8), 1381-1392. Pagano, M.E., Friend, K.B., Tonigan, J.S., & Stout, R.L. (2004). Helping others in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol*, 65, 766-773.

³⁵⁰ Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services*, 53(3), 310-316.

³⁵¹ Humphreys, K. & Moos, R.H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two year clinical and utilization outcomes. *Alcoholism: Clinical and Experimental Research*, 31(1), 64-68.

³⁵² White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W.L. & Kleber, H.D. (1998). Preventing harm in the name of help: A guide for addiction professionals. *Counselor*, 9(6), 10-17.

³⁵³ Bufo, C. (1991). *Alcoholics Anonymous: Cult or cure?* San Francisco: Sharp Press. Fransway, R. (2000). *12-Step horror stories*. Tucson, AZ: See Sharp Press. Gilliam, M. (1999). *How A.A. failed me*. New York: William Morrow. Peele, S. (1989). *The diseasing of America*. Lexington, MA: Lexington, Books. Ragge, K. (1998). *The real AA: Behind the myth of 12-Step recovery*. Tucson, Arizona: Sharp Press.

³⁵⁴ Ellis, A. (1985). Why Alcoholics Anonymous is probably doing more harm than good by its insistence on a higher power. *Employee Assistance Quarterly*, 1(1), 95-97. Hooked on recovery: The tyranny of the self-help movement. San Francisco Examiner's *Sunday Image* magazine, June 28, 1992. Rieff, D. (1991). Victims all? Recovery, co-dependency, and the art of blaming somebody else. *Harpers, October*, 49-56.

Collectively, these allegations include charges that AA:

- undermines personal autonomy and responsibility;
- encourages dependence on AA beyond the time that it is needed;
- discourages political activism via a focus on personal rather than social pathology;
- programs members to self-fulfill the prophecy of “one drink, one drunk,”
- coerces particular spiritual/religious beliefs;
- inhibits members from obtaining professional help;
- discourages members from taking needed medications; and
- tolerates exploitive sponsor-sponsee relationships.

Research to-date on iatrogenic effects of recovery mutual-aid involvement is very limited. Studies to-date have found the following:

- 1) AA and NA members are not discouraged from community participation, and such participation increases with length of sobriety.³⁵⁶
- 2) Some AA members disengage from active participation in AA and NA meetings but sustain long-term abstinence.³⁵⁷
- 3) AA members who continue attending meetings have a lower risk of relapse than those who stop attending.³⁵⁸
- 4) The potential of an “abstinence violation effect” (the idea that members who lapse are more likely to escalate to full-blown relapse because of the “one drink/one drunk” belief among 12-Step groups—the belief that escalation is inevitable because of a unique biological vulnerability over which they have no volitional control) has been theorized by behavioral therapists such as Marlatt,³⁵⁹ but studies to test this potential have shown mixed results.³⁶⁰

³⁵⁵ For examples of anti-AA web sites, see <http://www.orange-papers.org/> and http://www.aadeprogramming.org/index_frames.html.

³⁵⁶ Kurtz, L. & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems*, 30, 875-904.

³⁵⁷ Godlawski, T.M., Leukefeld, C., & Cloud, R. (1997). Recovery: With and without self-help. *Substance Use and Misuse*, 32, 621-627. Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, 29(11), 1983-1990.

³⁵⁸ Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, 29(10), 1858-1868.

³⁵⁹ Marlatt, G.A. (1978). Craving for alcohol, loss of control, and relapse: A cognitive behavioral analysis. In P.E. Nathan, G. A. Marlatt, & T. Loberk (Eds.), *Alcoholism: New directions in behavioral research and treatment* (pp. 271-314). New York: Plenum Press.

³⁶⁰ Birke, S.A., Edelmann, R.J & Davis, P.E. (1990). An analysis of the abstinence violation effect in a sample of illicit drug users. *Addiction*, 85(10), 1299-1307. Ruderman, A.J. & McKirnan, D.J. (1984). Development of a restrained drinking scale: A test of the abstinence violation effect among alcohol users. *Addictive Behaviors*, 9(4), 365-372. Stephens, R.S., Curtin, L., Simpson, E.E., & Roffman, R.A. (1994). Testing the abstinence violation effect construct with marijuana cessation. *Addictive Behaviors*, 19(1), 23-32.

- 5) AA member use of professional help after joining the organization is high (63% of AA members).³⁶¹
- 6) AA, as represented by attitudes of its local service representatives, is much more tolerant of medications for the treatment of addiction and co-occurring disorders than has been alleged.³⁶²

Whether injuries such as those alleged as effects of AA participation occur within recovery support groups—and the types, severity, and relevance of such injuries—are all legitimate and important questions for future scientific investigation. Such studies should compare:

- the potential for injury and variations in types of potential injuries across religious, spiritual, and secular recovery support groups;
- the comparative risk of injury from mutual-aid participation with the risk of injury within professionally directed addiction treatment; and
- the risk of harm in peer and professional interventions compared to the risks faced by persons with substance use disorders who fail to participate in either mutual aid or professional treatment.

POTENT INGREDIENTS OF RECOVERY MUTUAL AID

There is growing evidence that participation in recovery mutual-aid communities enhances long-term recovery outcomes, but the potent ingredients of such participation remain elusive and may differ across individuals at different stages of recovery. The mechanisms of change isolated to-date include:

- problem recognition and commitment to change;³⁶³
- regular re-motivation to continue change efforts;³⁶⁴
- counter-norms that buffer the effects of heavy drinking social networks and AOD use promotion in the wider culture;³⁶⁵

³⁶¹ Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

³⁶² Alcoholics Anonymous (1984). *The AA member: Medications and other drugs: Report from a group of physicians in AA*. New York: AA World Services. Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services*, 53(3), 310-316. Rychtarik, R.G., Connors, G.J., Dermen, K.H., & Stasiewics, P.R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, 61, 134-138.

³⁶³ Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768-777.

³⁶⁴ Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, 14, 376-389.

³⁶⁵ Emrick, C.D., Lassen, C.L., & Edwards, M.T. (1977). Nonprofessional peers as therapeutic agents. In A.S. Gurman & A.M. Rasin (Eds.), *Effective psychotherapy: A handbook of research* (2nd edition, pp. 120-161). Elmsford: Pergamon.

- sustained self-monitoring;³⁶⁶
- increased spiritual orientation;³⁶⁷
- enhanced coping skills, particularly the recognition of high-risk situations and stressors;³⁶⁸
- increased self-efficacy;³⁶⁹
- social support that offsets the influence of pro-drinking social networks;³⁷⁰
- helping others with AOD problems;³⁷¹
- exposure to sober role models and experience-based advice on how to stay sober;³⁷²
- participation in rewarding sober activities;³⁷³

³⁶⁶ Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103, 387-396.

³⁶⁷ Galanter, M. (2007). Spirituality and recovery in 12-Step programs: An empirical model. *Journal of Substance Abuse Treatment*, 33, 265-272. Zmore, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, 100(4), 447-450.

³⁶⁸ Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, 21(1), 54-60. Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103, 387-396.

³⁶⁹ Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768-777. Bogenschutz, M.P., Tonigan, J.S., & Miller, W.R. (2006). Examining the effects of alcoholism typology and AA attendance on self-efficacy as a mechanism of change. *Journal of Studies on Alcohol*, 67, 562.

³⁷⁰ Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R.L. (2001). Network support for drinking. In R. Longabaugh & P. W. Wirtz (Eds.), *Project MATCH hypotheses: Results and causal chain analyses* (NIAAA Project MATCH Monograph Series, Vol. 8, NIH Publication No 01-4238; pp. 260-275). Washington: Government Printing Office. Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R.L. (1998). Network support for drinking. Alcoholics Anonymous and long-term matching efforts. *Addiction*, 93, 1313-1333. Bond, J., Kaskutas, L. A., & Weisner, C. (2003). The persistent influence of social networks and Alcoholics Anonymous on abstinence. *Journal of Studies on Alcohol*, 64(4), 579-588. Laudet, A.B., Cleland, C.M., Magura, S., Vogel, H.S., & Knight, E.L. (2004). Social support mediates the effects of dual-focus mutual-aid groups on abstinence from substance use. *American Journal of Community Psychology*, 34, 175-85. Humphreys, K. & Noke, J. (1997). The influence of post-treatment mutual help group participation on the friendship networks of substance abuse patients. *American Journal of Community Psychology* 25(1), 1-16. Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, 21(1), 54-60. Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous. *Addiction*, 97(7), 891-900.

³⁷¹ Zmore, S.E., Kaskutas, L.E., & Ammon, L.N. (2004). In 12-Step groups, helping helps the helper. *Addiction*, 99, 1015-1023. Witbrodt, J. & Kaskutas, L.A. (2005). Does diagnosis matter? Differential effects of 12-Step participation and social networks on abstinence. *The American Journal of Drug and Alcohol Abuse*, 31, 685-707. Zmore, S.E. & Kaskutas, L.A. (2008). 12-Step involvement and peer helping in day hospital and residential programs. *Substance Use and Misuse*, 43, 1882-1903.

³⁷² Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous, *Addiction*, 97(7), 891-900.

- 24-hour accessibility of assistance,³⁷⁴ and
- potentially lifelong supports that do not require financial resources.³⁷⁵

ADDITIVE EFFECTS OF PROFESSIONAL TREATMENT AND MUTUAL AID

In studies of clinical populations, completion of addiction treatment *and* participation in recovery mutual-aid groups is more predictive of long-term recovery than either activity alone.³⁷⁶ There is a potential synergy between AA and treatment. People who attend recovery mutual-aid groups do better following addiction treatment than those who do not attend, regardless of the type of treatment they originally received,³⁷⁷ and those who participate in treatment and AA are also less likely to drop out of AA than those who only participate in AA.³⁷⁸ The potential role of recovery support groups and recovery community institutions takes on added significance in light of the present diminished access to treatment and diminished dose of treatment.³⁷⁹

³⁷³ Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103, 387-396.

³⁷⁴ Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous. *Addiction*, 97(7), 891-900.

³⁷⁵ Emrick, C.D., Lassen, C.L., & Edwards, M.T. (1977). Nonprofessional peers as therapeutic agents. In A.S. Gurman & A.M. Rasin (Eds.), *Effective psychotherapy: A handbook of research* (2nd edition, pp. 120-161). Elmsford: Pergamon.

³⁷⁶ Dawson, D.A., Grant, B.F., Stinson, F.S., & Chou, P.S. (2006). Estimating the effect of help-seeking on achieving recovery from alcohol dependence. *Addiction*, 101, 824-834.
 Fiorentine, R. & Hillhouse, M. (2000). Drug treatment and 12-Step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment*, 18(1), 65-74.
 Harrison, P.A. & Asche, S.E. (2001). Outcomes monitoring in Minnesota: Treatment implications, practical implications. *Journal of Substance Abuse Treatment*, 21, 173-183.
 Kelly, J.F. (2003). Self-help for substance-use disorders: History, effectiveness, knowledge gaps, and research opportunities. *Clinical Psychology Review*, 23(5), 639-663.
 Kisson, W., McLeod, C., & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, 26, 311-323.
 Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, 29(10), 1858-1868.
 Walsh, D.C., Hingson, R.W., Merrigan, D.M., Levenson, S.M., Cupples, L.A., Heeren, T., et al. (1991). A randomized trial of treatment options for alcohol-abusing workers. *New England Journal of Medicine*, 325, 775-782.

³⁷⁷ Tonigan, J.S., Connors, G.J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T.F. Babor & F.K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press.

³⁷⁸ Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, 29(10), 1858-1868.

³⁷⁹ Laudet, A. & Sands, B. (2007). An exploration of the effect of on-site 12-Step meetings on post-treatment outcomes among polysubstance-dependent clients. *Evaluation Review*, 31(6), 613-646.

AA can serve as an adjunct or alternative to addiction treatment.³⁸⁰ Sixty-three percent of AA members received professional help before coming to AA, and 63% received such help after joining AA, leaving 37% of AA members who received no professional support for their recovery before or after their affiliation with AA.³⁸¹ In comparison, 76% of people who participate in mental health support groups also receive professional help for the same problems.³⁸²

TIMING OF PARTICIPATION

Studies by Moos and Moos³⁸³ suggest advantages in linking individuals to recovery support groups prior to linkage to treatment. This allows those who can to resolve AOD problems without the financial and social burden of addiction treatment while enhancing outcomes for those who require professional treatment. In the 16-year treatment follow-up study, those who were exposed to AA prior to treatment had the highest post-treatment recovery rates. Persons who attend recovery support meetings as part of addiction treatment, and who are exposed to 12-Step literature and build 12-Step-related friendships and sponsorship relationships during treatment, are more likely to sustain 12-Step group participation after treatment than are those who are simply referred to support meetings at the end of treatment.³⁸⁴ Patterns of voluntary recovery mutual-aid participation established by adults during treatment tend to be sustained after treatment.³⁸⁵

³⁸⁰ Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, 60(4), 437-447.

³⁸¹ Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

³⁸² Kessler, R.C., Mickelson, K.D., & Zhao, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, 27, 27-45.

³⁸³ Moos R.H. & Moos B.S. (2004). Help-seeking careers: Connections between participation in professional treatment and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 26, 167-173. Moos, R.H. & Moos, B.S. (2006). Participation in treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals. *Journal of Clinical Psychology*, 62(6), 735-750.

³⁸⁴ Tonigan, J.S., Connors, G.J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T.F. Babor & F.K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press. Kelly, J.F. & Moos, R. (2003). Dropout from 12-Step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment*, 24(3), 241-250. Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, 29(10), 1858-1868.

³⁸⁵ Weiss, R.D., Griffin, M.L., Gallop, R., Onken, L.S., Gastfriend, D.R., Daley, D., et al. (2000). Self-help group attendance and participation among cocaine-dependent patients. *Drug and Alcohol Dependence*, 77, 177-184. Moos, R.H. & Moos, B.S. (2006). Participation in treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals. *Journal of Clinical Psychology*, 62(6), 735-750.

LINKAGE PROCEDURES AND PARTICIPATION RATES

Studies reveal that as many as 50% of clients who complete primary treatment for substance use disorders do not attend even one recovery support meeting following discharge from treatment.³⁸⁶ There is a direct relationship between clinician attitudes toward recovery support groups and successful referral rates to such groups, with successful referral rates declining as the clinician's attitudinal resistance towards such groups rises.³⁸⁷

Several studies have contrasted procedures of passive linkage to mutual-aid groups (procedures that involve verbal encouragement to attend and provision of a meeting list) with assertive linkage procedures. The latter procedures include orientation to the importance of recovery support group participation; introduction to support group choices and respective philosophies, language, and meeting rituals; encouragement to set goals for group participation; use of a volunteer "guide" to facilitate entry into recovery support group networks and meetings; provision of transportation to early meetings; and use of journaling to monitor responses to meetings.³⁸⁸ These assertive linkage procedures have been incorporated into manuals that clinicians and recovery support specialists can use as a rigorous introduction to particular recovery mutual aid cultures.³⁸⁹ Assertive linkage to recovery support groups early in addiction treatment increases post-treatment participation rates for adults³⁹⁰ and

³⁸⁶ Humphreys, K., Huebsch, P.D., Finney, J.W., & Moos, R.H. (1999). A comparative evaluation of substance abuse treatment: V. Substance abuse treatment can enhance the effectiveness of self-help groups. *Alcoholism: Clinical and Experimental Research*, 23(3), 558-63. Laudet, A. & Sands, B. (2007). An exploration of the effect of on-site 12-Step meetings on post-treatment outcomes among polysubstance-dependent clients. *Evaluation Review*, 31(6), 613-646.

³⁸⁷ Laudet, A. & White, W. (2005). An exploratory investigation of the association between clinicians' attitudes toward twelve-step groups and referral rates. *Alcoholism Treatment Quarterly*, 23(1), 31-45.

³⁸⁸ Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction* 101, 678-688.

³⁸⁹ See Kaskutas, L.A., Subbaraman, M., Witbrodt, J. & Zembere, S. (in press). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ), a group format 12-step facilitation approach. *Journal of Substance Abuse Treatment*.

³⁹⁰ Sisson, R.W. & Mallams, J.H. (1981). The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous and Al-Anon meetings. *American Journal of Drug and Alcohol Abuse*, 8, 371-376. McCrady, B.S., Epstein, E.E., & Hirsch, L.S. (1999). Maintaining change after conjoint behavioral alcohol treatment for men: Outcomes at six months. *Addiction*, 94, 1381-1396. Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction* 101, 678-688. Etheridge, R.M., Craddock, S.G., Hubbard, R.L., & Rounds-Bryant, J.L. (1999). The relationship of counseling and self-help participation to patient outcomes in DATOS. *Drugs and Alcohol Dependence*, 57, 99-112. Timko, C. & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-Step self-help groups: One-year outcomes. *Drug and Alcohol Dependence*, 90, 270-279. Walitzer, K.S., Dermen, K.H. & Barrick, C. (2009). Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical

adolescents.³⁹¹ Matching individuals to recovery support groups whose philosophies are congruent with their personal beliefs also enhances engagement.³⁹² At present, most addiction treatment programs do not routinely provide such assertive and individualized linkage procedures.³⁹³

LINKING ADOLESCENTS TO RECOVERY SUPPORT GROUPS

Problems in linkage between addiction treatment and recovery support groups are particularly pronounced for young people.³⁹⁴ Adults leaving addiction treatment are twice as likely to attend 12-Step meetings in the first three months than are adolescents discharged from addiction treatment.³⁹⁵ Studies of adolescents have found several key variables linked to non-affiliation with AA: a drug-using peer social network, a lack of prior treatment, greater parental involvement in treatment, and higher levels of hope.³⁹⁶ Adolescent affiliation with a recovery support group meeting rises in tandem with the percentage of young people attending.³⁹⁷ Adolescent affiliation rates and the benefits of participating in recovery support groups can be enhanced by participation in young people's meetings, but these specialty meetings are unavailable in many communities.³⁹⁸

Those who have studied linkage of adolescents to recovery support groups note several obstacles. The fact that members of young people's groups "age out" presents a unique problem related to group leadership and stability. Adolescents have also been found to have less problem recognition and motivation for abstinence, less identification with the stories and life issues of

-
- trial. *Addiction*, 104, 391-401. Kaskutas, L.A., Subbaraman, M., Witbrodt, J. & Zemore, S. (in press). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ), a group format 12-step facilitation approach. *Journal of Substance Abuse Treatment*.
- ³⁹¹ Passetti, L. L. & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs*, 40, 29-40.
- ³⁹² Atkins, R.G. & Hawdon, J.E. (2007). Religiosity and participation in mutual-aid support groups for addiction. *Journal of Substance Abuse Treatment*, 33, 321-331.
- ³⁹³ White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.
- ³⁹⁴ Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, 14, 376-389.
- ³⁹⁵ Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, 102, 81-93.
- ³⁹⁶ Hohman, L. & LeCroy, C.W. (1996). Predictors of adolescent AA affiliation. *Adolescence*, 31(122), 339-352.
- ³⁹⁷ Kelly, J.F., Myers, M.G., & Brown, S.A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse*, 15, 63-72.
- ³⁹⁸ Kelly, J.F., Myers, M.G., & Brown, S.A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse*, 15, 63-72.

older group members, and greater difficulty understanding or utilizing key recovery concepts.³⁹⁹

Passetti and Godley⁴⁰⁰ studied adolescent treatment center referrals to recovery support groups and found the highest rates of successful linkage within programs that:

- emphasized the sober social activities sponsored by support groups through such events as young people's conferences,
- worked with local support group service structures to identify particular meetings appropriate for young people,
- identified individuals to serve as role models and guides for young people,
- created networks of trusted people to accompany young people to meetings,
- monitored post-treatment attendance and response to meetings, and
- helped identify potential sponsors.

Little is known about the role of mutual-aid factors other than meeting attendance (e.g., the influence of a sponsor, home group, or step-work) on long-term adolescent recovery outcomes.⁴⁰¹

EARLY DROP-OUT RATES

Studies reveal that 40-60 % of adult clients who begin participation in 12-Step groups discontinue participation in the 9-12 months following treatment discharge.⁴⁰² Studies of post-treatment adolescent participation in 12-Step

³⁹⁹ Lora Passetti, Personal communication, December, 2008.

⁴⁰⁰ Passetti, L. L. & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs*, 40, 29-40.

⁴⁰¹ Kelly, J.F. & Myers, M.G. (2007). Adolescents' participation in Alcoholics Anonymous and Narcotics Anonymous: Review, implications, and future directions. *Journal of Psychoactive Drugs*, 39, 3, 259-269.

⁴⁰² Donovan, D.M. & Wells, E.A. (2007). "Tweaking 12-Step": The potential role of 12-Step self-help group involvement in methamphetamine recovery. *Addiction*, 102(Suppl. 1), 121-129. Kelly, J.F. & Moos, R. (2003). Dropout from 12-Step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment*, 24(3), 241-250. Laudet, A. & Sands, B. (2007). An exploration of the effect of on-site 12-Step meetings on post-treatment outcomes among polysubstance-dependent clients. *Evaluation Review*, 31(6), 613-646. Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, 29(10), 1858-1868. Tonigan, J.S., Connors, G.J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T.F. Babor & F.K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press. Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., et al. (2002). AA participation 10 years after Project MATCH treatment: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, 26(Supplement), 42A.

groups report similar attrition rates.⁴⁰³ (Attrition rates in non-12-Step groups have not been studied.) The short-term post-treatment outcomes of those who stop attending support meetings, or who attend them only sporadically, descend to the level of outcomes of those who report never regularly attending.⁴⁰⁴ This early drop-out rate is not unique to recovery mutual-aid participation and likely parallels attrition in other health improvement and social activities (for example, participation in exercise, dieting, and social clubs).

McIntyre conducted an analysis of the attrition data reported in the membership surveys that AA has conducted since 1968.⁴⁰⁵ He draws several conclusions that may apply to the broad spectrum of recovery support groups.

- The most significant period of attrition occurs during the first 90 days of exposure to AA.
- People who sustain participation beyond the first 90 days have significantly increased odds of sobriety 1-5 years later, compared to those who cease participation.
- Reducing or stopping meeting attendance after five years or more of sobriety is common and should not be viewed in the same way as early attrition, since most of those with this later pattern of disengagement remain sober, still consider themselves AA members, and continue to participate in special AA events.

McIntyre's findings on the importance of early engagement in the development of sustained affiliation with AA is confirmed by a 2008 analysis of AA membership survey data. In this study, 26% of AA members in their first month of attendance at AA meetings, and 56% of those in their fourth month, will still be involved in AA at one year.⁴⁰⁶ These data reinforce the importance of sustaining early engagement past an initial priming dose—a principle that would also be likely to apply to attendance patterns at other support groups (e.g., Weight Watchers) and health-related activities (e.g., health club participation following enrollment).

A critical point of evaluation for a recovery mutual-aid group is whether the group can attract and sustain the period of involvement needed to make the transition from recovery initiation to stable recovery maintenance. A critical point in the evaluation of P-BRSS is whether linkage procedures to communities of recovery are potent enough to sustain exposure beyond 90 days. We will now explore the dose of participation needed to achieve this transition.

⁴⁰³ Kelly, J.F., Myers, M.G., & Brown, S.A. (2002). Do adolescents affiliate with 12-Step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63, 293-304.

Kennedy, B. P. & Minami, M. (1993). The Beech Hill Hospital/Outward bound adolescent chemical dependency treatment program. *Journal of Substance Abuse Treatment*, 10, 395-406.

⁴⁰⁴ Kisson, W., McLeod, C., & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, 26, 311-23.

⁴⁰⁵ McIntyre, D. (2000). How well does A.A. work? An analyses of published A.A. surveys (1968-1996) and related analyses/comments. *Alcoholism Treatment Quarterly*, 18(4), 1-18.

⁴⁰⁶ Arthur S., Tom E. & Glenn C. (2008). Alcoholics Anonymous (AA) recovery outcome rates: Contemporary myth and misinterpretation. Accessed November 24, 2008 at <http://hindsfoot.orgt/recount01.pdf>.

DOSE AND INTENSITY OF PARTICIPATION EFFECTS

Studies of recovery mutual-aid groups reveal evidence of a dose effect (early recovery stability associated with increased meeting attendance)⁴⁰⁷ and an intensity effect (recovery stability increasing with broader patterns of participation in such activities as applying concepts to daily problem solving, reading recovery literature, sober socializing, service work).⁴⁰⁸

FREQUENCY OF PARTICIPATION

There are several key findings related to recovery support meeting participation. First, the advisability of initiating recovery via “90 meetings in 90 days” has never been tested scientifically,⁴⁰⁹ but this practice does provide intense support through what has been confirmed as the highest period of risk for disengagement and relapse.⁴¹⁰ Second, attending recovery mutual-aid meetings less than an average of once per week, at least during early recovery, is in effect equivalent to not attending meetings.⁴¹¹ Third, recovery outcomes from a medium level of sustained attendance at support group meetings is equivalent or superior in the long run to the recovery outcomes of those who go from high

⁴⁰⁷ Chappel, J. N. (1993). Long-term recovery from alcoholism. *Psychiatric Clinics of North America*, 16(1), 177-187. Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58(3), 231-238. Kelly, J.F., Stout, R.L., et al, 2006. following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research*, 30(8), 1381-1392. Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, 32(8), 1-11.

⁴⁰⁸ Cacciola, J.S., Dugosh, K., Foltz, C., Leahy, P., & Stevens, R. (2005). Treatment outcomes: First time versus treatment-experienced clients. *Journal of Substance Abuse Treatment*, 28, S13-S22. Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58(3), 231-238. Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment*, 12(4), 241-246. Sheeren, M. (1988). The relationship between relapse and involvement in Alcoholics Anonymous. *Journal of Studies on Alcohol*, 49(1), 104-106. Toumbourou, J.W., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment*, 23, 61-66.

⁴⁰⁹ Humphreys, K. & Kaskutas, L.A. (2007). *Continuity of care guidelines for participation in mutual help organizations before, during and after addiction treatment*. Presented at the 2nd Consensus Conference of the Betty Ford Institute, October 3-4, 2007.

⁴¹⁰ Hubbard, R. L., Flynn, P. M., Craddock, G., & Fletcher, B. (2001). Relapse after drug abuse treatment. In F. Tims, C. Leukfield, & J. Platt (Eds.), *Relapse and recovery in addictions* (pp. 109-121). New Haven: Yale University Press.

⁴¹¹ Fiorentine, R. (1999). After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, 25(1), 93-116.

initial intensity of participation to low intensity of participation.⁴¹² The latest AA membership survey⁴¹³ found that AA members attend an average of 2.4 meetings per week.

Passetti and colleagues looked at thresholds of recovery support group meeting attendance for adolescents in the 90 days prior to their six-month follow-up from addiction treatment. They found a strong link between meeting attendance and six-month abstinence rates. Thirty-nine percent of low attenders (with meetings attended 1-10 days in past three months) reported abstinence, whereas 70% of high attenders (meetings attended 63-90 days in past three months). Unfortunately, the former made up 90% of the sample and the latter only 2% of the sample.⁴¹⁴

DURATION OF PARTICIPATION

Some people require or benefit from lifelong participation in a recovery mutual aid fellowship.⁴¹⁵ In the 2004 AA membership survey, the average length of sobriety reported by members currently attending AA meetings was more than eight years.⁴¹⁶ This finding must be balanced against a growing number of studies documenting that a significant proportion of AA members decrease or stop meeting participation but continue their sobriety and other recovery-related activities.⁴¹⁷ However, those who continue to participate in AA after the first year

⁴¹² Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, 29(11), 1983-1990.

⁴¹³ Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

⁴¹⁴ Passetti, L.L., Dennis, M.L., Funk, B.S., Godley, S.H. & Godley, M.G. (2008). Effective thresholds of adolescent self-help meeting attendance and their predictors. Presented at the College on Problems of Drug Dependence, 2008.

⁴¹⁵ Humphreys, K. & Kaskutas, L.A. (2007). *Continuity of care guidelines for participation in mutual help organizations before, during and after addiction treatment*. Presented at the 2nd Consensus Conference of the Betty Ford Institute, October 3-4, 2007.

⁴¹⁶ Arthur S., Tom E. & Glenn C. (2008). Alcoholics Anonymous (AA) recovery outcome rates: Contemporary myth and misinterpretation. Accessed November 24, 2008 at <http://hindsfoot.org/recount01.pdf>.

⁴¹⁷ Tonigan, J.S. (2005). Patterns of AA attendance and drinking over a 10-year follow-up. *Alcoholism: Clinical and Experimental Research*, 29(Supplement), 381 (Abstract). Hoffmann, H.C. (2003). Recovery careers of people in Alcoholics Anonymous: Moral careers revisited. *Contemporary Drug Problems*, 30, 647-682. Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, 29(11), 1983-1990. Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., et al. (2002). AA participation 10 years after Project MATCH treatment: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, 26(Supplement), 42A. Laudet, A., Savage, R., & Mahmood, D. (2002). Pathways to long-term recovery: A preliminary investigation. *Journal of Psychoactive Drugs*, 34, 305-11. Weiss, R.D., Griffin, M.L., Gallop, R.G., Najavits, L.M., Frank, A., Crits-Christoph, P. et al.

of involvement have better long-term recovery rates than those who do not participate in AA or those who reduce or stop participation after one year of involvement.⁴¹⁸ Kelly and colleagues⁴¹⁹ conducted an 8-year follow-up of adolescents following addiction treatment and found that early AA exposure predicted enhanced long-term outcomes despite declining attendance rates over eight years. As noted, adult studies have found evidence of “nonattending participators,” who disengage from meetings but continue to sustain sobriety and other sobriety-related support activities.⁴²⁰

ROLE OF INTERNET-BASED RECOVERY SUPPORT⁴²¹

Online recovery support reduces barriers of time, distance, social status, and costs, but it may raise safety concerns for some groups (e.g., adolescents). Web-based recovery support groups (and telephone-based recovery support services) are reaching people who have not participated in face-to-face recovery support meetings, including many:

- adolescents,⁴²²
- women,⁴²³
- people with physical disabilities (e.g., people with hearing loss),⁴²⁴
- home-bound caregivers,
- status-conscious professionals (e.g., physicians, business executives, judges),⁴²⁵

(2005). The effect of self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence*, 77, 177-84.

⁴¹⁸ Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, 29(10), 1858-1868.

⁴¹⁹ Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, 32(8), 1-11.

⁴²⁰ Weiss, R.D., Griffin, M.L., Gallop, R.G., Najavits, L.M., Frank, A., Crits-Christoph, P. et al. (2005). The effect of self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence*, 77, 177-84.

⁴²¹ Kurtz, E. & White, W. (2007). *Telephone- and internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

⁴²² Humphreys, K. & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol*, 62(4), 528-532.

⁴²³ Alemi, F., Mosavel, M., Stephens, R. et al, (1996). Electronic self-help and support groups. *Medical Care*, 34(supplement), OS32-OS44. Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, 24(2), 161-167.

⁴²⁴ Cummings, J.N., Sproull, L., & Kiesler, S.B. (2002). Beyond hearing: Where real-world and online support meet. *Group Dynamics: Theory, Research, and Practice*, 6(1), 78-88.

⁴²⁵ Skinner, H., Maley, O., Smith, L., Chirrey, S., & Morrison, M. (2001). New frontiers: Using the Internet to engage teens in substance abuse prevention and treatment. In P.M. Monti,

- people in remote locations who have not had the opportunity to participate actively and on an equal basis with people who have higher levels of advantage,⁴²⁶ and
- non-dependent drinkers.⁴²⁷

Online support is also effective for individuals who have made initial progress during primary treatment but prefer an online format of continued recovery support.⁴²⁸

Particularly striking is the high percentage of women who use online support groups—a phenomenon likely linked to issues of accessibility, convenience, and safety. Hall and Tidwell's⁴²⁹ study of those using Internet-based recovery support services reported that women made up more than 60% of those using such services—a dramatically higher percentage than that found in treatment admissions and surveys of face-to-face recovery support groups. (See Table 6 in chapter four.)

From the onset of online support groups, it was assumed that online meetings would supplement face-to-face meetings. Surprisingly, an unknown percentage of individuals are initiating and sustaining recovery online without participation in face-to-face meetings. A day may come in the not-too-distant future when more people participate in online recovery support activities than participate in face-to-face meetings.

RELATIONSHIP BETWEEN HELPING AND HELPER RECOVERY OUTCOMES

Several studies have concluded that helping others (for example, sponsoring) improves one's own prognosis for recovery.⁴³⁰ Bohinc and

S.M. Colby, & T.A. O'Leary (Eds.), *Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions* (pp. 297-318). New York: Guilford.

⁴²⁶ Chong, J. & Herman-Stahl, M. (2003). Substance abuse treatment outcomes among American Indians in the Telephone Aftercare Project. *Journal of Psychoactive Drugs*, 35(1), 71-77.

Cudney, S. A. & Weinert, C. (2000). Computer-based support groups: Nursing in cyberspace. *Computers in Nursing*, 18(1), 35-43. Perron, B. (2002). Online support for caregivers of people with a mental illness. *Psychiatric Rehabilitation Journal*, 26(1), 70-77.

Weinert, C., Cudney, S., & Winters, C. (2005). Social support in cyberspace: The next generation. *CIN: Computers, Informatics, Nursing*, 23(1), 7-15.

⁴²⁷ Humphreys, K. & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol*, 62(4), 528-532.

⁴²⁸ McKay, J.R., Lynch, K.G., Shepard, D.S., & Pettinati, H.M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry*, 62(2), 199-207.

⁴²⁹ Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, 24(2), 161-167.

⁴³⁰ Cross, G.M., Morgan, C.W., Mooney, A.J., Martin, C.A. & Rafter, J.A. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism: Clinical and Experimental Research*,

Orensteen (1953)⁴³¹ conducted one of the earliest studies of AA by comparing those who were successful and those who were unsuccessful in achieving stable recovery in AA. They found that 66% of successful AA members had sponsored other AA members, whereas only 19% of unsuccessful AA members had served as sponsors. Cross and colleagues⁴³² conducted a follow-up study of inpatient alcoholism treatment and found that those former patients who served as AA sponsors had a 91% recovery rate. In the only study that has been conducted on the effects of sponsorship on inner-city injection drug use, Crape and colleagues⁴³³ found that sponsoring others significantly elevated recovery rates for injection drug users. Witbrodt and Kaskutas⁴³⁴ studied individuals with alcohol dependence, drug dependence, and alcohol and drug dependence. They found that involvement in peer service work was the best predictor of abstinence across all three diagnostic groups, and that peer helping activities during treatment predicted higher AA involvement after treatment. Also significant is a recent study finding that the benefits of helping within AA cross boundaries of gender, race, education, marital status, employment status, and past level of problem severity. Remarkably, this study also found that AA members with higher levels of depression were more likely to be involved in helping activities and that depressive symptoms lessened as a result of helping others.⁴³⁵

STUDIES OF FAMILY SUPPORT GROUPS

Research studies on recovery support groups for family members affected by severe AOD problems within the family are limited in number, scope

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- 14, 169-173. Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, 16(3), 321-337. Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., Vogel, H.S. & Knight, E.L. (2003). Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors*, 28, 399-413. Pagano, M.E., Friend, K.B., Tonigan, J.S., & Stout, R.L. (2004). Helping others in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol*, 65, 766-773. Zetmore, S.E., Kaskutas, L.E., & Ammon, L.N. (2004). In 12-Step groups, helping helps the helper. *Addiction*, 99, 1015-1023.
- ⁴³¹ Bohinc, E.A. & Orensteen, A.C. (1953). Evaluation of the services and programs of the Minneapolis Chapter of Alcoholics Anonymous. *Sociology*, 4, 181-195.
- ⁴³² Cross, G.M., Morgan, C.W., Mooney, A.J., Martin, C.A. & Rafter, J.A. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism: Clinical and Experimental Research*, 14, 169-173.
- ⁴³³ Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-Step treatment of injection drug users. *Drug and Alcohol Dependence*, 65, 291-301.
- ⁴³⁴ Witbrodt, J. & Kaskutas, L.A. (2005). Does diagnosis matter? Differential effects of 12-Step participation and social networks on abstinence. *The American Journal of Drug and Alcohol Abuse*, 31, 685-707.
- ⁴³⁵ Pagano, M.E., Zetmore, S., Onder, C.C. & Stout, R.L. (2009). Predictors of initial AA-related helping: Findings from Project MATCH, *Journal of Studies on Alcohol and Drugs*, 70, 117-125.

and methodological rigor. Most of what can be concluded about participation in such groups is limited to a small number of studies of Al-Anon and Alateen.

Information on Al-Anon and Alateen members is available from membership surveys that have been conducted since 1984. Table 9 contrasts Al-Anon membership characteristics in 1984 with those measured in 2006.

Table 9: Al-Anon Membership Characteristics in the United States, 1984 and 2006.

Al-Anon Membership Characteristic	1984	2006
% female	88%	85%
Average age	43.6	55
% of members who are Caucasian	96%	87% (7% Hispanic)
% with some college education	49%	80%
% urban and suburban	78%	82%
% referred to Al-Anon by a professional	35%	36%
% receiving professional help before joining Al-Anon	45%	60%
% receiving professional help after joining Al-Anon	44%	58%
Average duration of Al-Anon membership		11.3 years
% of members who left and returned to Al-Anon		41%
Average number of meetings attended per month		7*

* 5% of Al-Anon members participate in online meetings—an average of two online meetings per week.

Compared to members surveyed in 1986,⁴³⁶ Al-Anon members in 2006 are older and better educated, with a higher representation of women of color and a membership that is more likely to have sought professional help before and after coming to Al-Anon.

Profile information is also available for Alateen members. Members are an average of 14 years of age, predominately female (65%), and more ethnically diverse than members of other 12-Step fellowships (72% Caucasian, 13% Hispanic, 5% Native American, 3% African American and 1% Asian, 12% “mixed” or “other”). Only 8% of Alateen members are referred to Alateen by professional helpers, although 34% sought professional help before coming to Alateen and

⁴³⁶ 1986 data from Cermak, T.L. (1989). Al-Anon and recovery. *Recent Developments in Alcoholism*, 7, 91-104; Al-Anon Family Group Headquarters (2007). Membership Survey Results: Al-Anon Family Groups, 2006. Retrieved January 16, 2009 at: <http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf>

74% sought help after coming to Alateen. Alateen members attend an average of four Alateen meetings per month and have an average duration of participation of 2.4 years.⁴³⁷

Participation in family support groups in the addictions arena might be evaluated on a number of key dimensions, including effects of participation on: 1) understanding of and attitudes toward AOD problems, 2) physical and emotional health, 3) the marital/intimate relationship, 4) the health and functioning of children in the participant's family, 4) measures of family health (e.g., roles, rules, rituals), and 5) effects on help-seeking and recovery outcomes of the family member with an AOD problem. Regarding the last of these dimensions, it should be noted that the primary purpose of family recovery support groups is not to get the addicted family member into treatment or otherwise support the addicted family member's recovery. The primary focus of these groups is on enhancing the emotional health of members and the health of their families. Only 1% of Al-Anon members perceive the primary purpose of Al-Anon as being support of the alcoholic,⁴³⁸ in spite of the fact that a focus of Al-Anon evaluation studies has been on its effects on the alcoholic family member.

Studies of the effects of family group participation have until recently been only descriptive in nature.⁴³⁹

Studies to-date have drawn the following conclusions:

- Al-Anon attracts a diverse mix of family members, spouses, ex-spouses, and friends whose significant others include persons in stable recovery and persons who are actively drinking.⁴⁴⁰
- The self-esteem and marital adjustment of Al-Anon members improve with length of Al-Anon participation,⁴⁴¹ but improvements in marital adjustment, when they occur, are linked to prolonged Al-Anon participation and the spouse's sobriety and level of participation in AA.⁴⁴²
- Some studies reveal that the levels of family distress of AA members whose spouses attend Al-Anon do not differ from such levels in the families of AA members whose spouses do not attend Al-Anon, while

⁴³⁷ Al-Anon Family Group Headquarters (2007). Membership Survey Results: Al-Anon Family Groups, 2006. Retrieved January 16, 2009 at: <http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf>

⁴³⁸ Al-Anon Family Group Headquarters (2007). Membership Survey Results: Al-Anon Family Groups, 2006. Retrieved January 16, 2009 at: <http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf>

⁴³⁹ Cermak, T.L. (1989). Al-Anon and recovery. *Recent Developments in Alcoholism*, 7, 91-104.

⁴⁴⁰ Cutler, C.G. & Cutter, H.S. (1987). Experience and change in Al-Anon Family Groups: Adult children of alcoholics. *Journal of Studies on Alcohol*, 33, 1144-1146. Keinz, L.A., Schwartz, C., Trench, B.M. & Houlihan, D.D. (1995). An assessment of membership benefits in the Al-Anon program. *Alcoholism Treatment Quarterly*, 12(4), 31-38.

⁴⁴¹ Keinz, L.A., Schwartz, C., Trench, B.M. & Houlihan, D.D. (1995). An assessment of membership benefits in the Al-Anon program. *Alcoholism Treatment Quarterly*, 12(4), 31-38.

⁴⁴² Corenblum, B. & Fischer, D. (1975). Some correlates of Al-Anon group membership. *Journal of Studies on Alcohol*, 36, 65-73.

other studies find that family distress scores decline with extended participation in Al-Anon.⁴⁴³

- Participation in Adult Children of Alcoholics support groups engenders substantial changes in members' views of themselves and their families—changes linked to destigmatization of personal experience and increased self-acceptance and self-esteem.⁴⁴⁴
- In early studies of Al-Anon, Al-Anon participation was associated with the spouses of Al-Anon members achieving and sustaining sobriety.⁴⁴⁵
- In more scientifically rigorous studies, “Al-Anon has repeatedly been shown to be ineffective as a unilateral approach for engaging drinkers in treatment.”⁴⁴⁶
- Sisson and Azrin compared two approaches to using family members to initiate and support treatment of people with drinking problems: 1) education about the disease of alcoholism with a firm referral to Al-Anon; and 2) Community Reinforcement and Family Training, a program that included education and training on how wives could motivate drinkers to change their behavior via encouragement, consequences, scheduling competing activities, and management of drinking behavior and dangerous situations. None of the husbands in the education/Al-anon group sought treatment, while 86% of the husbands of CRAFT participants entered treatment.⁴⁴⁷
- Miller and colleagues conducted a study of treatment engagement rates comparing Al-Anon participation, the Johnson Institute intervention technique, and the CRAFT model; the resulting treatment engagement rates were 13% for Al-Anon, 23% for the Johnson Institute intervention, and 64% for CRAFT.⁴⁴⁸
- Meyers and colleagues compared three methods of engaging unmotivated drug users in treatment and found treatment engagement

⁴⁴³ McBride, J.L. (1991). Assessing the Al-Anon component of Alcoholics Anonymous. *Alcoholism Treatment Quarterly*, 8(4), 57-65.

⁴⁴⁴ Cutter, C.G. & Cutter, H.S. (1987). Experience and change in Al-Anon Family Groups: Adult children of alcoholics. *Journal of Studies on Alcohol*, 33, 1144-1146.

Humphreys, K. (1996). World view change in Adult Children of Alcoholics/Al-Anon self-help groups: Reconstructing the alcoholic family. *International Journal of Group Psychotherapy*, 46(2), 255-263. Kingree, J.B. (2000). Predictors and by-products of participation in a mutual help group for adult children of alcoholics. *Alcoholism Treatment Quarterly*, 18(2), 83-94.

⁴⁴⁵ Bailey, M. (1965). Al-Anon family groups as an aid to wives of alcoholics. *Social Work*, 10, 68-74.

⁴⁴⁶ Fernandez, A.C., Begley, E.A. & Marlatt, G.A. (2006). Family and peer interventions for adults: Past approaches and future directions. *Psychology of Addictive Behaviors*, 20(2), 207-213.

⁴⁴⁷ Sisson, R.W. & Azrin, N.H. (1986). Family-member involvement to initiate and promote treatment of problem drinkers. *Journal of Behavioral Therapy & Experimental Psychology*, 17(1), 15-21.

⁴⁴⁸ Miller, W.R., Meyers, R.J. & Tonigan, J.S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology*, 67, 688-697.

rates of 29% for Al-Anon/Nar-Anon-facilitation therapy, 58.6% for CRAFT, and 76.7% for CRAFT plus aftercare (up to six months of group sessions following individual sessions).⁴⁴⁹

- Alateen members are more likely than teenagers not in Alateen to view alcoholism as a medical rather than moral problem, to view recovery as possible through participation in support groups, and to believe that children were not responsible for their parents' heavy drinking.⁴⁵⁰
- Alateen members with an alcoholic parent report fewer negative moods, higher self-esteem, and less criminal justice involvement than teens in the same circumstances who do not participate in Alateen; Teens who participate in Alateen have levels of self-esteem and mood comparable to those of teens without an alcoholic parent.⁴⁵¹

In summary, participation in family recovery support groups enhances participants' understanding of addiction and hope for recovery, enhances their emotional health, and enhances family functioning following sustained duration of participation. Participation in these groups is not the most effective means of engaging unmotivated family members to seek addiction treatment.

In the next chapter, we will explore the effects of participation in other recovery support institutions.

⁴⁴⁹ Meyers, R.J., Miller, W.R., Smith, J.E. & Tonigan, J.S. (2002). A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology*, 70, 1182-1185.

⁴⁵⁰ Weber, J.A. & McCormick, P. (1992). Alateen members' and non-members' understanding of alcoholism. *Journal of Alcohol & Drug Education*, 37(3), 74-84.

⁴⁵¹ Hughes, J.M. (1977). Adolescent children of alcoholic parents and the relationship of Alateen to these children. *Journal of Counseling and Clinical Psychology*, 45(5), 946-947.

Chapter Five

Scientific Evaluation of Peer-based Services: Studies of the Effects of Participation in other Recovery Community Institutions

SUMMARY OF KEY FINDINGS

- There is a long history of recovery support institutions beyond mutual-aid fellowships (e.g., recovery community organizations, Recovery Community Centers, recovery-oriented social networking sites, and other online resources), but very little research exists on the effects of involvement in these institutions on long-term recovery.
- Participation in recovery social clubs reduces the risk of relapse following addiction treatment.
- Living within the national network of Oxford Houses significantly reduces the risk of relapse and enhances long-term recovery outcomes.
- Participation in recovery high schools and college/university-based recovery communities reduces the risk of relapse, enhances recovery outcomes, and elevates academic achievement.
- Recovery industries and recovery-conducive employment sites have yet to be described or evaluated extensively in the scientific literature.
- Religion-oriented recovery colonies, recovery ministries, and recovery churches are growing but remain all but invisible to the professional addiction treatment and research communities.
- Recovery support structures organized by and for recovering people within the context of addiction treatment, such as consumer councils and alumni associations, have not been evaluated scientifically.

From temperance hotels to recovery homes, and from the Drunkard's Club to AA Clubhouses and new recovery community centers, recovery support structures organized by and for recovering people have long played a role in addiction recovery in the United States. Surprisingly, the nature of this influence has been subjected to only limited scientific study. Two recent articles⁴⁵² highlight the recent growth of recovery community institutions: recovery

⁴⁵² Valentine, P., White, W., & Taylor, P. (2007). The recovery community organization: Toward a definition. Retrieved from http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

community organizations, recovery homes, recovery industries, recovery schools, recovery ministries and recovery churches, religious recovery colonies, recovery cafes, recovery book clubs, and recovery athletic teams, as well as a resurgence in recovery-focused consumer councils, alumni associations, and volunteer programs linked to addiction treatment institutions.

The presence and scope of these recovery support institutions are rarely acknowledged in the scientific literature and even more rarely evaluated with methodological rigor. Here is what we know to-date.

RECOVERY SOCIAL CLUBS

Considering the large number of studies conducted on recovery mutual aid meetings, it is surprising how little attention has been given to studying the effects of mutual-aid society clubhouses on recovery initiation and maintenance. A few studies are indicative of the potential of these recovery support institutions.

Hunt and Azrin⁴⁵³ described a self-governed social club for recovering alcoholics that was part of a more comprehensive community reinforcement approach (CRA) to alcoholism treatment. Those who participated in this CRA approach achieved superior outcomes as measured by decreased alcohol consumption, increased employment, and decreased hospitalization compared to matched control group members, but the role of the social club was not isolated for analysis. Two subsequent studies clarified this relationship. Mallams and Hall⁴⁵⁴ found that the social club reduced relapse rates, reduced treatment re-admission, and enhanced global functioning. Mallams, Godley, Hall, and Myers⁴⁵⁵ confirmed these effects and illuminated strategies for involving clients in the activities of the social club. They found that traditional referral procedures (providing each client with written information on the club and providing a single verbal statement of encouragement to attend) had little effect on initiating or sustaining club involvement. In contrast, systematic encouragement procedures significantly increased club participation. The procedures included an average of ten personal statements of encouragement to attend, letters sent describing scheduled club activities, provision of membership cards and club by-laws, resolving obstacles to participation, a warm welcome and praise from other members for attending, and assessing and providing preferred recreational activities at the club.

One clubhouse for adolescents exists in Kentucky as part of the Louisville Adolescent Network of Substance Abuse Treatment (LANSAT). According to their website (www.sevencounties.org), the youth clubhouse was designed to complement and expand an array of existing services by offering structured

⁴⁵³ Hunt, G.M. & Azrin, M.H. (1966). A community-reinforcement approach to alcoholism. *Behavior Research and Therapy*, 11, 91-104.

⁴⁵⁴ Mallams, J.H. & Hall, G.M. (1975). *An experimental social club for alcoholics and their families: A two year follow-up study*. Presented at the meeting of the Illinois Alcoholism and Drug Dependence Association, December.

⁴⁵⁵ Mallams, J.H., Godley, M.D., Hall, G.M., & Myers, R.J. (1982). A social systems approach to resocializing alcoholics in the community. *Journal of Studies on Alcohol*, 43, 1115-1173.

programming, recreational, and socialization opportunities in a drug-free and recovery-focused environment. The clubhouse is accessible to adolescents who have a desire to participate in activities and groups and are interested in decreasing use and/or maintaining sobriety. Adolescents may be in treatment, have completed treatment, or be affected by the use of family members. Structured groups offered include recovery support groups, skill development groups, special interest groups, and 12-Step meetings. Recreational activities include game night, basketball, shooting pool, and playing ping-pong. Tutoring and informal SAT/ACT assistance are also offered.⁴⁵⁶

RECOVERY COMMUNITY CENTERS

Many recovery community organizations are establishing recovery community centers as a central recovery “hub,” gathering place, and peer-based service center for people seeking or in recovery, and for their family members. These centers serve a clubhouse function in terms of recovery fellowship, but offer a much wider spectrum of recovery support services than would be available in a typical AA clubhouse. They also serve as an organizing place for recovery advocacy activities. The number of centers is growing rapidly, particularly in the Northeastern United States. For example, there are networks of recovery community centers in Connecticut, Pennsylvania, Vermont, New York, and New Hampshire. (See program profiles below.) The organizations that run these centers conduct their own internal evaluations, but no studies have been published on their effects on recovery initiation/maintenance; quality of life in recovery; or societal attitudes toward people in and/or seeking recovery, or toward their families.

⁴⁵⁶ Lora Passetti, Personal communication, December, 2008.

Program Profile 13: Vermont Recovery Center Network (VRCN)⁴⁵⁷

Purpose: Provide a venue for sober socializing, peer recovery support, recovery-focused community education, and recovery advocacy activities

Service Elements: Social support and fellowship; recovery support group meetings; recovery education and training; linkage to needed services; social activities; recovery advocacy.

Service Volume/Status: Currently nine recovery community centers across Vermont; approximately 70 hours per week of operation; supported primarily by 15 part-time staff and 150 volunteers (30,000 hours of volunteer support per year); 127 recovery support meetings per week held across nine centers; 143,903 visits to the nine centers in past year; 25% of visitors have less than a year of sobriety since completing treatment; 33% of visitors have never been in treatment; 20% of visitors are on probation or parole; current funding level is \$47,000 per center per year.

Service Outcomes: 50% of participants acknowledge VRCN role in recovery initiation; 88% acknowledge VRCN role in recovery maintenance; the employment of visitors to the centers increased from 36% at initial contact to 50% at follow-up; reported homelessness decreased from 25% at initial visit to 12.5% at follow-up.

Service Lessons: 1) Recovery centers (RCs) must be wanted and driven by recovery community; 2) where RCs failed in VT, they did so due to lack of perceived need and lack of grassroots organizing that preceded their opening; 3) importance of idea of RC without walls—an RC that organizes events using available community facilities rather than a designated building; 4) importance of moving RC beyond creation of a 12-Step clubhouse; 5) importance of funding diversification to enhance sustainability.

For More Information: Contact Patty McCarthy at RecoveryVT@aol.com and Mark Ames at vtrecoverynetwork@gmail.com.

⁴⁵⁷ Personal communication with Patty McCarthy, Executive Director, Friends of Recovery Vermont; additional information in White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

Program Profile 14: Philadelphia Recovery Community Center⁴⁵⁸

Purpose: A collaborative effort between the Philadelphia Office of Addiction Services and PRO-ACT to provide a venue for the delivery of peer-based recovery support services (opened December, 2007).

Service Elements: 1) Life-skills education; 2) recovery coaching; 3) recovery plan development; 4) educational/employment coaching; 5) family support and relationship enhancement; 6) parenting training; 7) special interest support groups; 8) sober leisure; and 9) community service projects.

Service Volume/Status: In first eleven months of operation, the Recovery Community Center had 3279 visitors, provided 161 workshops and 21 other skill-building opportunities to 793 individuals, trained 61 volunteers who contributed more than 2,451 hours to the Center, and made 206 referrals to addiction treatment programs.

Service Outcomes: 6-month follow ups indicated that in the employment/education category a 41.7 % increase occurred in employment and/or school attendance; those reporting stable living environments increased from 23.1% at intake to 46.2 % (reporting a permanent place to live) at 6-month follow up; 100% reported no crime or involvement with the criminal justice system within the past 30 days; and 100% reported that they believed they were socially connected.

Service Lessons: 1) Importance of conveying history and tenets of recovery movement—making people feel a part of something larger than themselves; 2) importance of conveying that everyone has something to give as well as receive from recovery center participation; 3) need to re-emphasize continually that the center is a place for fellowship and community, rather than therapy; 4) importance of stage-appropriate activities that “set people up for success,” with success contingent upon skills and support; 5) importance of wide mix of activities to appeal to diverse needs of recovery community members; 6) creating a safe place for people to acknowledge a lapse/relapse episode speeds re-initiation of recovery stability; 7) a source of personal shame (e.g. prison) can be transformed into an asset that can be used to help others.

For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

RECOVERY HOMES

Recovery homes were founded on the proposition (and growing evidence) that sobriety-supportive living environments can elevate recovery outcomes.⁴⁵⁹ There is a long history of residential therapies and halfway and

⁴⁵⁸ Personal communication with Bev Haberle, December, 2008

⁴⁵⁹ Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*, 20(4), 427-441. Jason, L., Davis, M., Ferrari, J., & Bishop, P. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education* 31(1), 1-27. King, M. P. & Tucker, J. A. (2000). Behavior change patterns and strategies distinguishing moderation drinking and abstinence during the natural resolution of alcohol problems without

three-quarter-way houses, all fueling the modern recovery home movement.⁴⁶⁰ Residents in these facilities are expected to work, pay their rent, and provide each other mutual support within an environment that may or may not include professional-directed treatment services.

Today, the term “recovery home” is used loosely—too loosely—to describe a continuum of recovery-focused housing services that range from staff-directed residences that in earlier periods were referred to as halfway and three-quarter way houses to self-managed residences of recovering people. The latter constitute hidden resources that exist in a growing number of communities. A recent survey of such homes in Philadelphia showed 25 recovery homes receiving financial support from the Department of Behavioral Health, while another 250 such homes were financially self-supported by their residents.⁴⁶¹ The same survey revealed wide variation in quality of the physical facilities, depth of recovery orientation, and degree of connection to the local community.

The predominant recovery home model is Oxford House. Founded in 1975, Oxford House has grown to include more than 1,200 recovery homes occupied by more than 24,000 recovering people a year in 48 states.⁴⁶² The Oxford Houses are multiple-bedroom dwellings segregated by gender and located in stable neighborhoods judged to be conducive to recovery. Nearly 200 of the homes are for women, and 34 are designed specifically for women and children.⁴⁶³

The Oxford House model has several distinctive features:

- democratic self-governance,
- financial self-support of each home by its members,
- shared house chores,
- reliance on support from peers rather than paid staff,
- no required exclusive pathway of recovery (e.g., no mandated treatment participation or AA attendance),
- self-determined lengths of stay,
- an expectation of complete and enduring abstinence, and
- the expulsion of anyone who uses alcohol or drugs.⁴⁶⁴

treatment. *Psychology of Addictive Behaviors*, 14(1), 48-55.

⁴⁶⁰ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁴⁶¹ Johnson, R., Martin, N., Sheahan, T., Way, F., & White, W. (2008). *Recovery resource mapping: Results of a Philadelphia recovery home survey*. Philadelphia: Department of Behavioral Health and Mental Retardation Services.

⁴⁶² Molloy, P. & White, W. (in press). Oxford Houses: Support for recovery without relapse. *Counselor*. Oxford House (2006). *Oxford House comes of age: Oxford House—The model*. Presented at the 8th Oxford House World Convention, Wichita, KS, September 21-24, 2006.

⁴⁶³ d'Arlach, L., Olson, B.D., Jason, L.A., & Ferrari, J.R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, 31(1/2), 121-131.

⁴⁶⁴ Ferrari, J.R., Jason, L.A., Davis, M.I., Olson, B.D., & Alvarez, J. (2004). Similarities and differences in governance in drug and/or alcohol misuse recovery: Self vs. staff rules and regulations. *Therapeutic Communities*, 25(3), 185-198. Jason, L.A., Davis, M.I., Ferrari, J.R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, 31(1), 1-27.

The Oxford Houses provide residents considerably more personal liberties (e.g., the ability to bring personal belongings, personal choice of daily schedule, freedom to leave for weekends, and “private time” with guests in their rooms) than would be found in most residential treatment settings or therapeutic communities.⁴⁶⁵

Leonard Jason and his colleagues at DePaul University’s Center for Community Research have evaluated this model extensively. Major findings from their studies include the following.

- Oxford House residents present a profile of gender and ethnic diversity, high alcohol and drug problem severity, and rates of co-occurring psychiatric disorders comparable to those of addiction treatment populations.⁴⁶⁶
- Alcoholics Anonymous is the dominant framework of recovery for Oxford House residents (76%), but other pathways of recovery are also respected (with 17% reporting individual psychotherapy as their primary recovery support medium).⁴⁶⁷
- At 2-year follow-up, residents who stayed in an Oxford House for a minimum of six months following residential addiction treatment had superior recovery outcomes compared to those placed in traditional aftercare and had higher rates of employment, higher incomes, and significantly lower rates of arrest.⁴⁶⁸
- The prospects of long-term recovery rise with length of stay in an Oxford House.⁴⁶⁹
- At extended follow-up, 69% of residents continue to live in the house or have left as planned and in good standing.⁴⁷⁰

Jason, L.A., Olson, B.D., Ferrari, J.R., Layne, A., Davis, M.I., & Alvarez, J. (2003). A case study of self-governance in a drug abuse recovery home. *North American Journal of Psychology*, 5(3/4), 1-16.

⁴⁶⁵ Ferrari, J.R., Jason, L.A., Davis, M.I., Olson, B.D., & Alvarez, J. (2004). Similarities and differences in governance in drug and/or alcohol misuse recovery: Self vs. staff rules and regulations. *Therapeutic Communities*, 25(3), 185-198.

⁴⁶⁶ Ferrari, J.R., Curtin-Davis, M., Dvorchak, P., & Jason, L. (1997). Recovering from alcoholism in communal living settings: Exploring the characteristics of African American men and women. *Journal of Substance Abuse*, 9, 77-87. Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*, 32, 803-818.

⁴⁶⁷ Nealon-Woods, M.A., Ferrari, J.R., & Jason, L.A. (1995). Twelve-step program use among Oxford House residents: Spirituality or social support in sobriety? *Journal of Substance Abuse*, 7, 311-318.

⁴⁶⁸ Jason, L.A., Olson, B.D., Ferrari, J.R., Majer, J.M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, 102, 1114-1121. Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, 96, 1727-1729.

⁴⁶⁹ Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*, 32, 803-818.

⁴⁷⁰ Majer, J., Jason, L., Ferrari, J.R., & North, C. (2002). Co-morbidity among Oxford House residents: A preliminary outcome study. *Addictive Behaviors*, 27, 837-845.

- Women's Oxford Houses that accommodate children have a positive effect both on the mothers and on the other women in the house.⁴⁷¹
- The communal environment of the Oxford House has been found to be particularly congruent among African American men and women and members of other groups whose historical experience has created a distrust of authority figures.⁴⁷²
- Psychiatric severity does not constitute an impediment to successful recovery within Oxford House.⁴⁷³
- Community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses.⁴⁷⁴

Recovery within the Oxford Houses has been conceptualized as the transition from a destructive dependency on drugs to a constructive dependency on recovery peers.⁴⁷⁵

Two system-wide efforts to map and/or organize recovery homes are described in Program Profiles 15 and 16:

⁴⁷¹ d'Arlach, L., Olson, B.D., Jason, L.A., & Ferrari, J.R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, 31(1/2), 121-131.

⁴⁷² d'Arlach, L., Olson, B.D., Jason, L.A., & Ferrari, J.R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, 31(1/2), 121-131. Ferrari, J.R., Curtin-Davis, M., Dvorchak, P., & Jason, L. (1997). Recovering from alcoholism in communal living settings: Exploring the characteristics of African American men and women. *Journal of Substance Abuse*, 9, 77-87.

⁴⁷³ Majer, J.M., Jason, L.A., North, C.S., Ferrari, J.R., Porter, N.S., Olson, B., Davis, M., Asse, D., & Molloy, P. (2008). A longitudinal analysis of psychiatric severity upon outcomes among substance abusers residing in self-help settings. *American Journal of Community Psychology*, 42(102), 145-153.

⁴⁷⁴ Jason, L.A., Roberts, K., & Olson, B.D. (2005). Attitudes towards recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology*, 33(5), 529-535.

⁴⁷⁵ Nealon-Woods, M.A., Ferrari, J.R., & Jason, L.A. (1995). Twelve-step program use among Oxford House residents: Spirituality or social support in sobriety? *Journal of Substance Abuse*, 7, 311-318.

Program Profile 15: Recovery Home Survey (Philadelphia, PA)⁴⁷⁶

Purpose: 1) To map the number and location of recovery homes and other recovery support services in the city of Philadelphia, 2) to compare the depth and zip code location of recovery support services to areas of greatest need as revealed by zip code analysis of AOD problem indicator data.

Service Elements: Site visits were conducted at all identified recovery homes in the City of Philadelphia; each recovery home was rated on physical plant, recovery programming, and community involvement; recovery home survey data were compared to other recovery resource and AOD problem indicator data by Philadelphia zip code.

Survey Outcomes: 1) 22 funded and 267 unfunded recovery homes were identified; 2) funded homes rated considerably higher in quality than unfunded homes; 3) zip codes were identified as having high problem severity and low recovery capital, and these zip codes can be targeted for future recovery resource development.

Service Lessons: 1) “You can’t judge a book by its cover”: Some very attractive homes have little recovery programming, while some unattractive homes have vibrant recovery cultures; 2) Recovery home surveys can weed out boarding houses (with active drinking) that misrepresent themselves as recovery homes; 3) It is possible to analyze AOD problems and recovery resources by zip codes within a community.

For More Information: Contact Fred Way at FWay@pmhcc.org or 215-790-4973

Program Profile 16: Connecticut Community of Addiction Recovery’s Recovery Housing Project

Purpose: 1) Establish a state-of-the-art database of all recovery houses www.findrecoveryhousing.com in Connecticut; 2) organize interested recovery home owners to form the statewide Recovery Housing Coalition of Connecticut; 3) establish minimum standards to open and operate recovery homes via the Recovery Housing Coalition of Connecticut, to ensure good-quality housing for people in recovery; and 4) provide training to potential owners on how to establish a recovery home.

Service Elements: Recovery House owners were invited to participate in the Recovery Housing Coalition of Connecticut, which developed a set of standards that they believed would “set the bar high,” ensuring that recovery housing in CT was safe and affordable. Site visits were conducted at all identified recovery homes in CT; each owner was asked to agree to the standards set forth. www.findrecoveryhousing.com was launched, with more than 80 houses listed. Referrals to Recovery Houses continue at about 100 per week.

⁴⁷⁶ Johnson, R., Martin, N., Sheahan, T., Way, F. & White, W. (2008). Recovery Resource Mapping: Results of a Philadelphia Recovery Home Survey. Philadelphia Department of Behavioral Health and Mental Retardation Services.

Connecticut Community of Addiction Recovery's Recovery Housing Project (Continued)

Survey Outcomes: 1) Identified more than 170 houses, of which 80 are currently listed on www.findrecoveryhousing.com; 2) conducted site visits and surveys at each Recovery House (the other 80 are currently being contacted); 2) saw more than 30 new homes established as a result of the "So, You want to Open a Recovery House" Training; 3) held monthly meetings of Recovery Housing Coalition of CT and began updating its standards; 4) provided linkage between recovery home owners and state agencies, to enhance referrals and the quality of recovery housing.

Service Lessons: 1) www.findrecoveryhousing.com allows owners to update their bed availability, but it has been a challenge to persuade them to do it themselves; 2) there continues to be a huge need for safe, affordable, funded recovery homes; 3) Recovery Housing Coalition of CT has become a group of very passionate owners who want to ensure the quality of recovery housing in CT.

For More Information: Contact Cheryle Pacapelli at cheryle@ccar.us or 860-244-2227

When local recovery community organizations (RCOs) conduct focus groups to assess the needs of the recovery community, recovery-supportive housing is always near the top of the priority lists that are generated. As a result, many RCOs are developing or encouraging the development of self-governed, self-supported recovery homes. They are also finding creative ways to link people in need to these homes. (See findrecoveryhousing.org.)

RECOVERY COLONIES

Recovery colonies—whole communities made up of recovering people—have a history that dates to the late nineteenth century. At that time, it was discovered that alcoholics who initiated recovery through the Christian rescue missions in urban America were in need of a setting for more extended healing. Religion-sponsored recovery colonies such as Keswick Colony of Mercy, founded in 1897, grew in response to this need.⁴⁷⁷ Here is a brief account based on the author's visits to a recovery colony.

In 1962, Mickey and Laura Evans had a vision and a calling to build a camp for recovering alcoholics in the South Florida wilderness. That vision turned into Dunklin Memorial Camp, which has for more than 45 years served individuals and families wounded by alcohol and other drugs. The first striking characteristic of Dunklin is its remoteness. The question, "Are we lost?" is common on first and subsequent journeys to the area. As one enters Dunklin, what one finds is a self-contained and self-sufficient community. Driving through the community, one passes

⁴⁷⁷ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

multiple dormitories, homes for staff, homes for resident families and families who visit on weekends, a mess hall, a tabernacle, a school, a computer lab, a library, a lumber mill and furniture workshop, hog and cattle pens, fruit groves and sugar cane fields, a health clinic, rodeo grounds, and a cemetery. Effusive love connects the members of this community. Work crews circle in prayer before beginning work in the various industries; hugs abound as the community enters the mess hall for lunch, and prayers precede each meal—real prayers, personal prayers, rather than those memorized and delivered in rote. This is not a treatment center; it is a healing community. From its humble beginnings, the Dunklin vision has expanded to encompass a larger vision of residential recovery, family recovery, ministry training, and the development of new cities of refuge (Dunklin-type communities around the world) and outreach through jail and prison ministries and Overcomers Groups in local communities. That vision has already extended Dunklin's work across the Southeastern United States and Costa Rica, and into South America. Dunklin Memorial Camp is part of the growing network of addiction recovery colonies in the United States.

A secular variant of the religious recovery colony can be found in efforts to create recovery villages (for example, as units within public housing projects or specialty programs within shelters) where recovering individuals and their families can sustain themselves in a recovery-conducive physical and social environment.⁴⁷⁸

Recovery colonies are all but invisible to the public, and the mainstream addiction treatment field and the research community seem to be completely unaware of their existence.

RECOVERY SCHOOLS⁴⁷⁹

Recovery high schools have saved my life.

—Stefanie K., Recovery High School Student⁴⁸⁰

One of the newest recovery community institutions is the recovery school. This institution provides support for recovering students within what has been

⁴⁷⁸ Graham, A. V., Graham, N. R., Sowell, A., & Ziegler, H. (1997). Miracle Village: A recovery community for addicted women and their children in public housing. *Journal of Substance Abuse Treatment*, 14(1), 275-284. Leaf, P. J., Thompson, K. S., Lam, J. A., Jekel, J. F., Armand, E. T., Evans, A. E., et al. (1993). Partnerships in recovery: Shelter-based services for homeless cocaine abusers. New Haven. *Alcoholism Treatment Quarterly*, 10(3-4), 77-90.

⁴⁷⁹ White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

⁴⁸⁰ Finch, A.J. (2007). Authentic voices: Stories from recovery school students. *Journal of Groups in Addiction and Recovery*, 2, 16-37.

described as an “abstinence-hostile environment.”⁴⁸¹ Between 1977 and 2000, collegiate recovery school programs were established at Brown University, Rutgers University, Texas Tech University, and Augsburg College. Collegiate recovery programs were established between 2001 and 2004 at Dana College, Grand Valley State University, Case Western Reserve University, University of Texas at Austin, and Loyola College in Maryland. Since Ecole Nouvelle (now Sobriety High) in Minnesota was opened in 1986 as the first recovery high school, the growth of high school programs specifically for recovering students has quickened. Twenty-five recovery high schools opened across the United States between 1999 and 2005. This rapid growth sparked the formation of the Association of Recovery Schools.⁴⁸²

Recovery school programs vary in their design, but generally combine special recovery support services, with an emphasis on academic excellence. The former may include special faculty guidance, recovery dorms, recovery support meetings, recovery drop-in centers, sober social activities, and peer mentoring. The latter is achieved through academic guidance, study centers, and peer-tutoring programs. Preliminary studies of these programs confirmed high rates of uninterrupted abstinence (70-80%); early intervention and retention of students following lapse; and excellent academic performance as measured by grades (well above the student average), class attendance rates (90-95%), and the number of students in recovery high schools going on to college (65%).⁴⁸³

Gibson⁴⁸⁴ conducted a study of a school-based recovery support (RSS) curriculum established in 1986 for Wichita Southeast High School students returning from residential treatment. Students who qualified for RSS but did not enroll were used as a control group. The major findings included 1) an 82% recovery rate for the students enrolled in the RSS, 2) a high rate of school withdrawal for those students who qualified but did not participate in RSS, and 3) significant improvements in school attendance and family relationships for RSS students. Students reported that RSS served as an effective bridge from treatment to recovery and helped address their feelings of anxiety, isolation, and self-consciousness; concerns about making new friends; and academic performance.

⁴⁸¹ Cleveland, H.H., Harris, K. S., Baker, A. K., Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment*, 33(1), 13-23.

⁴⁸² White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58.

⁴⁸³ White, W. L. (2001b). Recovery university: The campus as a recovering community. *Student Assistance Journal*, 13(2), 24-26. White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58.

⁴⁸⁴ Gibson, R.L. (1991). *School-based recovery support: The time is now*. Presented at the annual convention of the American Association of Counseling and Development, Reno, Nevada, April 21-24.

Moberg and Finch⁴⁸⁵ conducted a study of 18 recovery high schools in six states over the course of three semesters. They found that recovery high schools:

- operate under a variety of names, including *recovery school*, *sober school*, *alternative school*, *charter school*, and *learning center*;
- usually have small enrollments (12-25 students);
- receive financial support primarily through a mix of public and private funding; and
- serve to support recovery maintenance rather than recovery initiation.

Weekly substance use for the students in the Moberg/Finch survey dropped from 90% prior to entrance into a recovery school to 7% at the time of the survey, with 56% of students reporting continuous abstinence since their enrollment in a recovery school. Students in the recovery school survey also reported decreased emotional problems and increased personal progress, particularly academic progress.

Harris and colleagues⁴⁸⁶ conducted a study of a campus recovery community at Texas Tech University (TTU). Elements of this program include 1) financial assistance for recovering students entering or returning to college, 2) support from the staff at the Center for the Study of Addiction and Recovery (CSAR), 3) daily on-campus 12-Step meetings, 4) seminars on addiction and recovery, 5) a system of peer mentoring for recovery support and academic coaching, 6) parent and family weekends on campus, and 7) an expectation of community service. They found that students within the Texas Tech collegiate recovery community had a 3.18 grade point average, a 70% graduation rate, and a relapse rate of only 8%. A separate study of the TTU campus recovery community from 2003-2006 confirmed the high level of academic achievement and found a within-semester relapse rate of only 4.4%.⁴⁸⁷ This is a striking rate of recovery when one considers the environmental context of this achievement and the fact that more than half of those completing addiction treatment in the United States use alcohol and/or drugs within 12 months post-discharge.⁴⁸⁸

Botzet and colleagues have reported on Augsburg College's StepUP Program. This program included options for drug- and alcohol-free living environments, weekly one-to-one and group recovery support meetings, sobriety contracts, sober social activities, and behavioral requirements that included attending AA/NA and other campus recovery support meetings. They reported outcomes for 46 current students and 37 alumni. Only one student presently

⁴⁸⁵ Moberg, D.P. & Finch, A.J. (2007). Recovery high schools: A descriptive study of school programs and students. *Journal of Groups in Addiction and Recovery*, 2(2-4), 128-161.

⁴⁸⁶ Harris, K., S. Baker, A.K., Kimball, T.G., & Shumway, S.T. (2007). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction and Recovery*, 2(2-4), 220-237.

⁴⁸⁷ Cleveland, H.H., Harris, K. S., Baker, A. K, Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment*, 33(1), 13-23.

⁴⁸⁸ White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

enrolled reported substance use in the past six months, and none met criteria for current substance use disorders. Eight (21.6%) former students reported one or more episodes of alcohol or drug use in the previous six months, and only one student surveyed (2.7%) met criteria for a current substance use disorder in the past six months.

*The overwhelming majority of current StepUP students is not using drugs, is maintaining a favorable GPA, is functioning quite well socially, and perceives the StepUP program as vital to their overall well being.*⁴⁸⁹

PEER-BASED OCCUPATIONAL RECOVERY SUPPORT

Those admitted to addiction treatment have high unemployment rates and a high need for employment counseling,⁴⁹⁰ but employment counseling, vocational training, and job-seeking skills training are not standard components of most addiction treatment programs, nor are assertive linkages to these services routine components of specialty-sector addiction treatment.⁴⁹¹ There has been an unstated assumption that successful recovery will by itself increase employment, but studies have drawn three conclusions that challenge this assumption: 1) providing standard addiction treatment does not in itself significantly increase post-treatment employment rates,⁴⁹² 2) post-treatment employment status is not a predictor of abstinence (suggesting that successful recovery is possible without stable employment),⁴⁹³ and 3) programs that place greater emphasis on combinations of ancillary services such as sober housing and employment have better recovery outcomes than those that offer strictly clinical interventions.⁴⁹⁴

The importance of establishing financial self-sufficiency is underscored by the finding that recovery outcomes can be compromised by low socio-economic status.⁴⁹⁵ To achieve the goal of economic self-sufficiency, new recovery support

⁴⁸⁹ Botzet, A.M., Winters, K., & Fahnhorst, T. (2007). An exploratory assessment of a college substance abuse recovery program: Augsburg College's StepUP Program. *Journal of Groups in Addiction and Recovery*, 2(2-4), 257-287.

⁴⁹⁰ Hser, Y., Polinsky, M. L., Maglione, M., & Anglin, M. D. (1999). Matching clients' needs with drug treatment services. *Journal of Substance Abuse Treatment*, 16(4), 299-305.

⁴⁹¹ Room, J. (1998). Work and identity in substance abuse recovery. *Journal of Substance Abuse Treatment*, 15(1), 65-74.

⁴⁹² Magura, S. (2003). The role of work in substance dependency treatment: A preliminary overview. *Substance Use and Misuse*, 38(11-13), 1865-1876.

⁴⁹³ Reif, S., Horgan, C. M., Ritter, G. A., & Tompkins, C. P. (2004). The impact of employment counseling on substance user treatment participation and outcomes. *Substance Use and Misuse*, 39(13 & 14), 2391-2004.

⁴⁹⁴ Kaskutas, L. A., Ammon, L. N., & Weisner, C. (2004). A naturalistic analysis comparing outcomes of substance abuse treatment programs with different philosophies: Social and clinical model perspectives. *International Journal of Self Help and Self Care*, 2, 111-133.

⁴⁹⁵ McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association* 284(13), 1689-1695.

organizations such as Recovery at Work in Atlanta are experimenting with recovery work co-ops as a transition from treatment to mainstream employment. These co-ops are small businesses within the recovery community that help people in recovery return to mainstream employment or obtain such employment for the first time. Such services integrate the opportunity for stable employment with disengagement from criminal enterprises, resolution of existing legal problems, participation in community life, and acts of community service. They also attempt to address the discrimination that recovering people, particularly those with addiction-related criminal histories, face in seeking employment.

Program Profile 17: Recovery Oriented Employment Services, Hartford, CT (Connecticut Community of Addiction Recovery)

Purpose: Pilot employment project in which a Recovery Community Organization (RCO) collaborates with local treatment providers in Hartford, Willimantic, and New London, CT to: 1) help people in recovery become active members of their communities; 2) combine treatment, case management, vocational training, and recovery support; and 3) link persons in recovery needing employment with recovery-friendly businesses.

Service Elements: 1) Treatment providers screen clients for employment needs and assist with vocational choices, a vocational plan, and referrals; 2) the RCO provides job readiness training, on-the-job recovery strategies, telephone recovery support, employment-focused support groups, and opportunities for participation in other recovery support services and recovery-focused service activities.

Service Volume/Status: The pilot program in Hartford began in July, 2008; the Willimantic pilot in September, 2008; and the New London program in February, 2009. Between 7/1/08 and 12/31/08, 151 clients had been enrolled, with 21 currently enrolled. 72 participants have obtained employment. Recovery Friendly Business coalition meetings began in December, 2008 and continue on a monthly basis.⁴⁹⁶

Service Lessons: 1) Transportation challenges continue to limit participants' ability to find employment. 2) Community stigma surrounding addiction, gaps in work histories, and arrest records are also major stumbling blocks to employment. 3) Participants rely on support from Recovery Community Center throughout the training and employment process.

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Initiatives like Recovery at Work and Recovery Oriented Employment Services assume that employment is a support for and an outcome of recovery, but a pilot study by Godley, Passetti, and White suggests that employment plays a more complex role in adolescent recovery from substance use disorders. They found a consistent relationship between days of full-time employment and increased days of AOD use during the six months following discharge from treatment. Possible explanations for this finding include the influence of AOD-

⁴⁹⁶ Personal communication with Linda Guillorn, CT Department of Mental Health and Addiction Services, January, 2009.

using colleagues in the workplace, availability of income to purchase alcohol and other drugs, and conflicts between work schedules and recovery support activities.⁴⁹⁷ This finding underscores the potential need for recovery-conducive employment opportunities for adolescents and special recovery supports for employed adolescents in recovery.

As noted earlier, occupational recovery support groups also exist, but there is a marked absence of studies evaluating whether participation in these groups as an adjunct or alternative to 12-Step or other recovery support groups elevates long-term recovery outcomes. The exception to this lack of research involves professional peer assistance programs organized for high-status professional groups such as physicians, nurses, attorneys, and airline pilots.⁴⁹⁸ The most extensive research has been conducted on the physician health programs (PHPs) that have long provided a peer-based framework for recovery for addicted physicians.

A recent review of available PHP research confirmed the exceptionally high recovery rates of physicians participating in PHPs—70-96% across studies. These exceptional recovery rates were linked to: 1) educational programs that promote early referral; 2) peer-based intervention services; 3) comprehensive evaluations; 4) linkage to abstinence-based, comprehensive treatment; 5) sustained peer-based support; and 6) long-term monitoring (for at least five years).⁴⁹⁹ Those of us involved in this review of PHPs left that experience wondering why all Americans did not have access to such key service elements. The fact that the highest recovery rates in the scientific literature include sustained support and strong peer-based recovery components deserves broader attention from the providers of treatment and recovery support systems and their funding and referral sources.⁵⁰⁰

RECOVERY MINISTRIES/RECOVERY CHURCHES

Special ministries to alcoholics and addicts began in the closing decades of the nineteenth century, through religion-sponsored urban rescue missions and the creation of rural inebriate colonies. This movement was spawned by pioneering institutions that included the Water Street Mission in New York City and the Salvation Army. A resurgence of such ministries followed the rise of juvenile narcotic addiction in the 1950s and 1960s and included street outreach performed by Father Dan Egan, the “Junkie Priest,” in New York City; outpatient

⁴⁹⁷ Godley, S.H., Passetti, L.L. and White, M.K. (2006). Employment and adolescent alcohol and drug treatment: An exploratory study. *American Journal on Addictions*, 15, 137-143.

⁴⁹⁸ Fletcher, C. E. (2004). Experience with peer assistance for impaired nurses in Michigan. *Journal of Nursing Scholarship*, 36(1), 92-93.

⁴⁹⁹ White, W.L., DuPont, R.L., & Skipper, G.E. (2007). Physicians health programs: What counselors can learn from these remarkable programs. *Counselor*, 8(2), 42-47.

⁵⁰⁰ DuPont, R.L., McLellan, A.T., White, W.L., Merlo, L.J. & Gold, M.S. (2009). Setting the standard for recovery: Physician Health Programs, *Journal of Substance Abuse Treatment*, 36, 159-171.

counseling clinics like Saint Mark's Clinic in Chicago; and residential rehabilitation programs like Teen Challenge.

The involvement of the faith community in the problem of addiction and recovery is not new, but this involvement has expanded greatly and taken some stunning new turns. These recent developments exist on a continuum of involvement that spans:

- “recovery-friendly churches” that welcome recovering people but offer no special recovery services;
- churches sponsoring explicitly religious recovery mutual-aid groups such as Celebrate Recovery and Victorious Ladies;
- mega-churches adding a “recovery pastor” to their staff;
- small churches using lay leaders and volunteers to lead recovery support meetings;
- church-sponsored, recovery-focused worship services, workshops, leadership training, and children's programs;
- Recovery Churches (e.g., Central Park Recovery Church in St. Paul, Minnesota; the Recovery Church in Charlotte, North Carolina; and the Christian Recovery Fellowship in Dryden, Maine) whose identities are based on the recovery focus of their ministries;
- new faith-based recovery colonies (residential communities) such as Dunklin Memorial Camp in Okeechobee, Florida;
- a new association of recovery ministries, the National Association for Christian Recovery (<http://www.nacronline.com>); and
- The growth of non-Christian recovery ministries and support groups such as Millati Islami.

The religious branches of the American recovery movement are experiencing a reawakening and a historically unprecedented degree of influence within the mainstream church. This trend is particularly evident in African American communities⁵⁰¹ and has been aided, in part, by the new Access to Recovery federal initiative described in Chapter Seven.

Most of the research on the role of faith-based recovery ministries is observational rather than controlled. White, Woll, and Webber reviewed the long history of Project SAFE in Illinois, a project aimed at treating addicted women with histories of abuse or neglect of their children. In this review, Project SAFE clinical staff frequently observed that African American women initiated their recovery through traditional frameworks that included professional treatment, AA, NA, and recovery homes, but that later (12-18 months into recovery), many of them shifted to the church as their primary recovery support institution,

⁵⁰¹ Sanders, M. (2002). The response of African American communities to alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 20(3/4), 167-174. Watson, D.W., Bisesi, L., Tanamly, S., Sim T., Branch, C.A. & Williams, E. (2003). The role of small and medium-sized African-American churches in promoting healthy life styles. *Journal of Religion and Health*, 42(3), 191-200. Williams, C., with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco.

particularly to churches that had strong recovery ministries.⁵⁰² This finding is consistent with a study by Stewart,⁵⁰³ who found a link between post-treatment abstinence and regular practice of one's religious faith among African Americans, and Crepe and colleagues'⁵⁰⁴ study of 500 former and current injection drug users in Baltimore, in which participation in church functions was strongly associated with sustained abstinence. However, these constitute only preliminary findings and may be contradicted by others. For example, a recent study by Roland and Kaskutas examined the effects of spirituality and religiosity and involvement in AA among African Americans, Caucasians, and Hispanics. One of their findings was that African Americans reported high AA attendance and church attendance at follow-up, but that they were not more likely than other groups to reduce AA participation in tandem with increased church involvement.⁵⁰⁵

OTHER RECOVERY SUPPORT STRUCTURES

Other recovery support structures are also emerging within local communities—recovery advocacy organizations, recovery bookstores, recovery cafes, recovery art co-ops, recovery social networking web sites, recovery athletic teams, and recovery-based travel groups, to name a few—but there are no studies on the influence of participation in these structures on recovery outcomes. Most surprising is that searches of the addictions literature fail to identify focused studies on those recovery support structures most closely linked to addiction treatment: consumer councils and alumni associations.

⁵⁰² White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*.

Chicago: Illinois Department of Human Services, Office of Alcoholism and Substance Abuse.

⁵⁰³ Stewart, C. (2007). Religiosity as a predictor of successful post-treatment abstinence for African-American clients. *Journal of Social Work Practice in the Addictions*, 7(4), 75-92.

⁵⁰⁴ Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-Step treatment of injection drug users. *Drug and Alcohol Dependence*, 65, 291-301.

⁵⁰⁵ Roland, E.J. & Kaskutas, L.A. (2002). Alcoholics Anonymous and church involvement as predictors of sobriety among three ethnic treatment populations. *Alcoholism Treatment Quarterly*, 20, 61-77.

Program Profile 18: NET Consumer Council (NorthEast Treatment Centers, Philadelphia, PA)

Purpose: Enhance clients' participation in agency policy development and ownership of their recovery processes.

Service Elements: 1) Weekly Consumer Council meetings with elected consumers and agency representatives; 2) monthly Consumer Recognition Day; 3) *Recovery Focus*, a regular consumer council newsletter; 4) consumer peer mentor program (peer mentors assigned to all new clients); 5) consumer volunteer program (outreach and community service work); 6) Community Living Program (a consumer-directed recovery skills training and recovery coaching program delivered to men residing in the NET Wharton Center, an inpatient residential rehabilitation program); 7) The NET Community Recovery Center (a consumer-operated drop-in center); and 8) the Consumer Speakers Bureau.

Service Volume/Status: Since its creation in August 2006, 90%+ participation from 14 revolving CC representatives; average of 120 consumers at monthly consumer recognition dinner.

Service Outcomes: Increased daily attendance rates, completion rates, and successful rates of transfer to another level of care; decreased levels of power struggles between clients and staff; greater client involvement in treatment.

Service Lessons: Empowering clients increases personal motivation for recovery and also increases motivation for professional staff; outreach moves recovery into the life of the community.

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Today there are growing numbers of new, innovative recovery support institutions developing outside of professional addiction treatment and outside of recovery mutual-aid fellowships. These institutions are likely to exert a profound influence on future opportunities for sustained recovery for individuals, societal attitudes about hope for recovery among people still struggling with addiction, and policymaker attitudes toward investing in recovery, as well as on the future of peer-based support services. In the next chapter, we will review what the science tells us about recovering people who work in the field of addiction treatment as staff and volunteers.

Chapter Six

Scientific Evaluation of Peer-based Services: Studies of Recovering People Working in Addiction Treatment

SUMMARY OF KEY FINDINGS

- The portrayal of recovering people working in the addictions field is plagued by misconceptions and stereotypes that are contradicted by the available scientific evidence.
- The percentage of counselors in personal recovery within specialty sector addiction treatment workforce has declined from nearly 70% in the early 1970s to approximately 30% in 2008.
- Recovery status alone does not predict pre-practice educational performance or performance on addiction counselor certification tests.
- Studies of addiction counselors in the United States have *not* found that addiction counselors in recovery are more or less effective than addiction counselors who are not in recovery, but recovering counselors are as effective as counselors who are not in recovery.
- The key determinants of effectiveness do not include recovery status. The effectiveness of counselors in personal recovery, like that of counselors not in recovery, varies widely from person to person.
- Recovering people working in addiction treatment are paid less than people not in recovery for comparable work, even when their educational credentials are equal.
- Studies of the personalities of recovering men and women working as addiction counselors reveal few differences from counselors without addiction recovery backgrounds.
- Much of what has been attributed to recovering counselors by way of beliefs and attitudes is a function of educational level; as educational levels of people in recovery have increased, differences between recovering counselors and counselors without addiction histories diminish or disappear completely.
- Attitudes toward evidence-based practices differ by educational levels, but not by recovery status (when education levels are controlled).
- People in recovery do not constitute a homogenous group: attitudes/beliefs, clinical effectiveness, and the quality of ethical sensitivity and decision-making cannot be predicted based on recovery status.
- Studies of the relapse rates of recovering addiction counselors over the past 40 years report relapse rates ranging between 5% and 38%, with rates progressively declining through these years.

- The evaluation of treatment models delivered primarily by counselors in personal recovery report recovery outcome rates similar or superior to those of programs whose services are delivered by staff without recovery backgrounds.
- Volunteer programs in addiction treatment relying primarily on volunteers in personal/family recovery have been evaluated positively; volunteer programs declined in popularity within the field throughout the 1980s and 1990s but are increasing in tandem with renewed calls for peer-based recovery support services.

SCIENCE VERSUS STEREOTYPES

The portrayal of the attitudes, beliefs, knowledge, and performance of recovering people working as addiction counselors, and of their degree of representation in the addiction treatment workforce, continues to be plagued by misconceptions and stereotypes that are contradicted by most scientific studies. The prevailing view is that the majority of addiction counselors are in recovery; that most recovering counselors do not have college or advanced degrees; and that recovering counselors differ in their attitudes, beliefs, knowledge, skills, and effectiveness from addiction counselors without addiction/recovery backgrounds.⁵⁰⁶

Anderson and Wiemer's portrayal in the 1990s of the generally perceived differences between recovering counselors and counselors without a history of addiction varies little from such portrayals in the 1970s.

1992: *Professionals are described as formal, impersonal, and calculating, whereas nonprofessionals are described as empathetic, spontaneous, dedicated, optimistic, and immune to manipulation by clients.*⁵⁰⁷

1979: *Subjective evaluations have tended to characterize professional and paraprofessional counselors and their orientations toward clients in dichotomous terms. Professional counselors were reputed to be formal, impersonal, and calculating, while paraprofessionals, and especially ex-addict paraprofessionals, were said to be empathic, understanding and spontaneous.*⁵⁰⁸

⁵⁰⁶ Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73, 596-603.

⁵⁰⁷ Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73, 596-603, quotation from p. 596.

⁵⁰⁸ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports*. (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

This chapter will separate fact from myth regarding such differences. We will try to draw broad conclusions about the character and level of effectiveness of addiction counselors who are in recovery, while noting that the designation “counselor in recovery” represents not a homogenous group, but men and women with diverse addiction/recovery careers and styles of helping.

RECOVERY REPRESENTATION IN ADDICTION TREATMENT

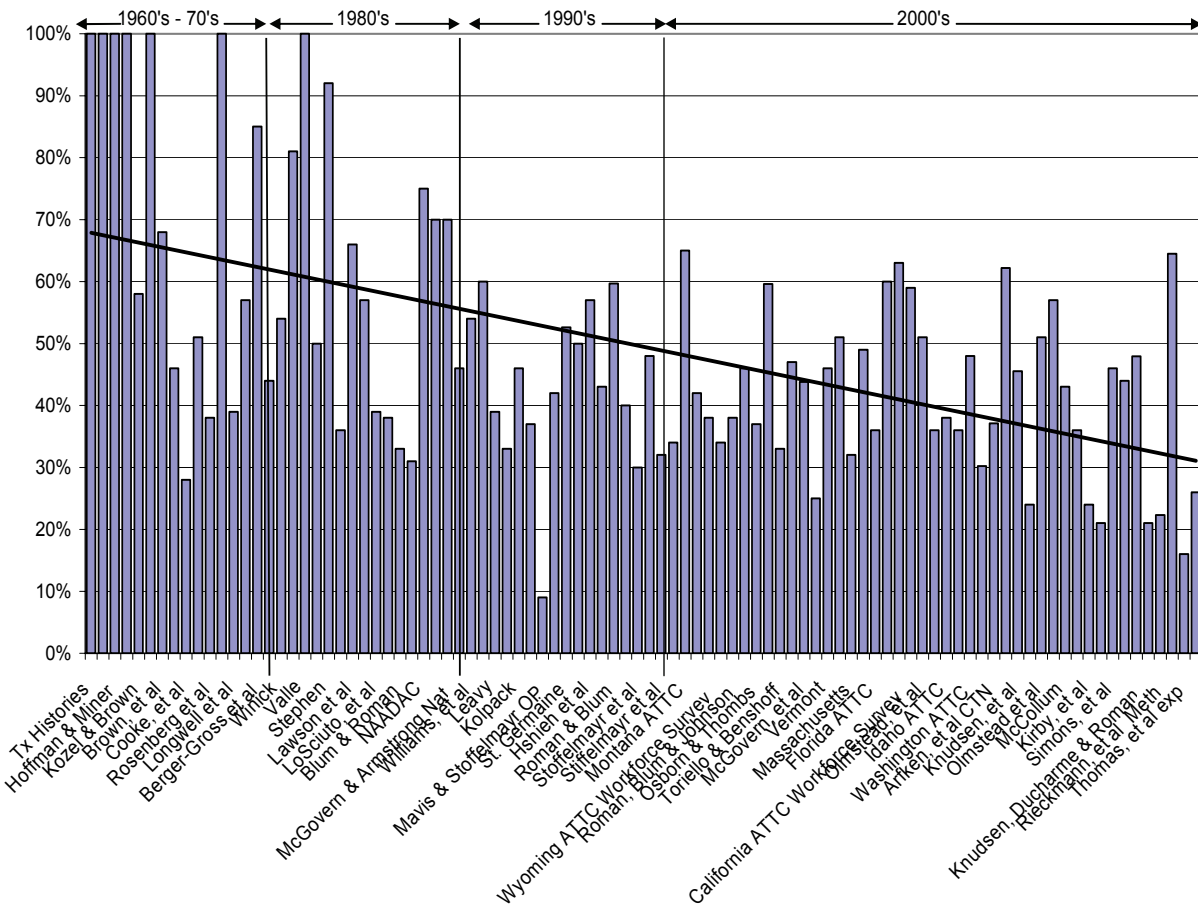
Tenured observers of the addiction treatment field in the United States suggest that the percentage of recovering people working as addiction counselors has declined significantly in recent decades,⁵⁰⁹ but the change of recovery representation in the addiction treatment field has not been systematically studied. Analyzing this trend is compromised by the fact that many recent clinical studies and surveys of the addiction treatment workforce did not ask participants to indicate their recovery status.⁵¹⁰

⁵⁰⁹ Winick, C. (1990). The counselor in drug user treatment, *International Journal of the Addictions*, 25(12a), 1479-502. Brown, B. S. (1993). Observations on the recent history of drug user counseling. *The International Journal of the Addictions*, 28(12), 1243-1255. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁵¹⁰ The following workforce surveys contain no reference to recovery representation: Forman, R.F., Bovasso, G., & Woody, G. (2001). Staff beliefs about addiction treatment. *Journal of Substance Abuse Treatment*, 21, 1-9. Knudsen, J.R., Gallon, S.L., & Gabriel, R.M. (2006). Relating substance abuse counselor background to the provision of clinical tasks. *Journal of Psychoactive Drugs*, 38(4), 473-481. McCarty, D., Forman, R., Fuller, B.E., Laws, R., Arfken, C., Magruder, K.M., et al. (2007). Direct care workers in national drug abuse treatment clinical trials network: Characteristics, opinions, and beliefs. *Psychiatric Services*, 58(2), 181-190. Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, 24(1), 51-7. Ogborne, A.C., Wildt, T.C., Braun, K., & Newton-Taylor, B. (1998). Measuring treatment process beliefs among staff of specialized addiction treatment services. *Journal of Substance Abuse Treatment*, 15, 301-312.

Table 10 summarizes recovery representation in the addiction treatment workforce as reported in 39 studies/surveys conducted between 1960 and 2007. (See the Appendix for a detailed presentation of these studies.) The reader's ability to draw conclusions from this data is challenged by the different ways in which such information has been collected. Some workforce surveys and studies ask participants to note their recovery status, some ask for designation of family recovery (existence of a participant's family member in recovery), some combine these categories, and more recent workforce surveys are less likely to ask questions related to recovery status.

Table 10: Recovery Representation Among Counselors Working in Addiction Treatment: 1960-2007¹



If all recovery representation reports are reviewed by decade, several conclusions can be drawn.

- Histories and studies of addiction treatment from the mid-1960s through the early 1970s note very high recovery representation rates, with counseling staff from many residential alcoholism treatment programs and residential therapeutic communities reporting rates of recovery representation between 60% and 100%. Recovery representation in early outpatient treatment and methadone maintenance treatment programs was considerably lower.
- Between 1974 and 1975, staff recovery representation rates dropped to approximately 50%.
- In the early 1980s, staff recovery representation dropped into the 30th percentile, but these data were reported in local studies and may not be representative of national trends. Winick (1991)⁵¹¹ found that staff recovery representation rates in New York City's therapeutic communities had dropped from nearly 100% to 54%. One national study of this period⁵¹² reported a 57% recovery representation rate among alcoholism counselors.
- National studies between 1984 and 1990⁵¹³ report staff recovery representation rates ranging from 39% to 75%.
- During the 1990s, recovery representation rates in available state surveys ranged from 39% to 46%, and two national surveys revealed staff recovery representation rates of 57%⁵¹⁴ and 59.7%,⁵¹⁵ the latter reflecting a survey of 400 private addiction treatment programs. By 2002, staff recovery representation in this same sample of private programs declined to 39%.⁵¹⁶
- Between 2000 and 2008, staff recovery representation rates in available surveys ranged from 25% to 65%, with most studies reporting rates in the 30th and 40th percentiles.
- Recovery representation in public-sector treatment is highest in those modalities treating clients with the highest degrees of problem severity

⁵¹¹ Winick, C. (1991). The counselor in drug user treatment. *International Journal of the Addictions*, 25(12A), 1479-1502.

⁵¹² Birch & Davis Associates (1983). *Development of model professional standards for counselor credentialing*. Rockville, MD: NIAAA.

⁵¹³ LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, 19(3), 233-252. McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, 4(1), 43-60. NAADAC (1986). *Survey of substance abuse counselors*. Arlington, VA: NAADAC: The Association of Addiction Professionals.

⁵¹⁴ Hsieh, S.Y. & Srebalus, D.J. (1997). Alcohol treatment issues: Professional differences. *Alcoholism Treatment Quarterly*, 15(4), 63-73.

⁵¹⁵ Roman, P. & Blum, T. (1999). *National Treatment Center Study: Summary Report (No. 4): Results of Treatment Center Staff Questionnaires and New Center / Old Center Comparisons*. Athens, GA: Institute for Behavioral Health.

⁵¹⁶ Roman, P., Blum, T., & Johnson, A. (2002). *National Treatment Center Study: Summary Report (No. 5): Third Wave Results*. Athens, GA: Institute for Behavioral Health.

and complexity (detoxification and residential treatment); for-profit, hospital-based addiction treatment programs have the lowest representation of recovering people working as counselors.⁵¹⁷

- Recovery representation is higher in abstinence-based programs than in medication-assisted recovery programs.⁵¹⁸
- Recovery representation among counselors working in Minnesota Model alcoholism programs and drug-free therapeutic communities has declined from nearly 100% in the 1960s to below 60%.

What have not been reported consistently enough to note trends are recovery representation status trends by age, gender, ethnicity, and drug choice, and only sparse information exists on recovery representation among persons filling non-clinical recovery support service roles.

Program Profile 19: Peer Specialist Initiative (Philadelphia, PA)⁵¹⁹

Purpose: 1) Demonstrate to service recipients, service professionals and behavioral health leaders the value that experiential wisdom and experience-based skills can add to the service system; 2) increase the number of Certified Peer Specialists throughout the Philadelphia behavioral health care system; 3) create employment opportunities for people in recovery; 4) develop agency norms that celebrate hope for recovery and nurture the development of peer recovery cultures; 5) cultivate more active, more participatory roles for service consumers. (Initiative launched November, 2006)

Service Elements: 1) Recruitment, 2) interview/orientation on nature of training/certification, 3) two-week peer specialist training program (20 per class), 4) consultation with peers to evaluate effects of employment on Social Security Disability benefits, 5) program orientation for agency leaders, 6) two-day training program for supervisors of peer specialists, 7) monthly peer specialist development seminars for graduates, 8) bi-monthly seminars for agency supervisors of peer specialists.

Volume/Status: A total of 130 peer specialists trained and certified to-date.

⁵¹⁷ Mulligan, D.H., McCarty, D., Potter, D., & Krakow, M. (1989). Counselors in public and private alcoholism and drug abuse treatment programs. *Alcoholism Treatment Quarterly*, 6(3-4), 75-89. Rieckmann, T., Daley, M., Fuller, B.E., Thomas, C.P., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications for treatment of opioid dependence. *Journal of Substance Abuse Treatment*, 32, 207-215. Roman, P. & Blum, T. (1998). *National Treatment Center Study: Summary Report (No. 3): Second Wave On-Site Results*. Athens, GA: Institute for Behavioral Health.

⁵¹⁸ Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1987). Attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, 175, 653-660. Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1988). Differences among treatment clinic types in attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, 176, 714-718.

⁵¹⁹ Personal communication with Joan King and Tom O'Hara, November/December 2008.

Peer Specialist Initiative (Continued)

Service Outcomes: 90% of those enrolled achieved successful certification; all those certified received six college credits; 76 graduates hired—74% full time and 26% part time; 72.5% of those hired are still employed (a high retention rate in a field noted for high staff turnover); a survey is underway to evaluate obstacles faced by those certified but not yet hired. Agencies with peer specialists now viewed as being on “cutting edge”; there is competition to develop peer specialists within agencies.

Service Lessons: 1) Infrastructure of program (above-listed elements) is crucial to success, 2) financial incentives and system-wide recognition of peer initiatives aid recruitment of participating agencies, 3) agency competition is part of initiative-aided success, 4) peer specialist initiative generated a contagious energy that helped agencies transform themselves, 4) requiring each organization to submit a transformation plan for the program in which the peer specialist would be employed prevented the peer specialist initiative from becoming an appendage to an otherwise unchanged program.

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THE ROLE TRANSFORMATION OF ADDICTION COUNSELORS IN RECOVERY

There are no formal studies on how the core activities and service relationships of the non-degreed, “paraprofessional” recovering counselor has changed through professionalization of the addiction counselor role. It may be that no significant differences ever existed between recovering counselors and counselors without addiction histories, or that differences once existed but those differences were erased through the processes of academic/professional education and socialization.

Our earlier historical review suggests that the core ideas, functions, and relational style of the addiction counselor have changed throughout the era of professionalization. These have included changes in attitudes toward self-disclosure, role model functions, liaison with recovery communities, experience-based recovery coaching, seeing clients in their natural environments, and socializing with clients.⁵²⁰ Such changes are important in that they set the stage for their revival through P-BRSS. As traditional professionals assumed ownership of the addiction treatment field, the frequent unspoken message to recovering counselors entering the field was, “You can join us if you forsake your recovery identity and learn to think, feel, speak, look, and act like us.” If the professionalization of recovering counselors has eliminated the unique ingredients that historically contributed to the recovery support process, and if they are now indistinguishable from professional helpers without recovery background, then recovery representation in the field no longer has meaning or value.

⁵²⁰ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

The recovery status of the helper has meaning only if that status contributes something to the recovery experience that is not provided by people not in recovery. As more scientific investigation of P-BRSS takes place, it is critical that information on recovery status and other ingredients be examined carefully. For example, the issue of recovery representation will be moot if the recovery status of people working in treatment as P-BRSS service providers cannot be disclosed, or if these employees cannot draw upon their experiential knowledge and relational connections with local recovery communities in the performance of their roles—and clients cannot draw upon their own knowledge of that recovery status as a source of hope and a model for recovery-based decision-making and living.

In their description of the value of paraprofessionals in the treatment and recovery process, Talbott and colleagues⁵²¹ observed: “We see the paraprofessional’s talents and skills as different from the professional’s, rather than merely an extension of them.” Early alcoholism counselors feared that these talents might be lost in the rush to professionalize the field.

*With standardization comes an exclusiveness, an isolation, a power block, a kind of thinking and procedure that mitigates against an informality that has characterized the counselor’s worth. Efforts at certification and qualification standards for AA member-alcoholism counselors should be approached slowly and prudently.*⁵²²

In the subsequent professionalization of addiction counseling, we may well have diluted if not lost those unique qualities.

We first rendered the peer helpers extensions of the professional (by defining them as “paraprofessional”), then we turned the peer helper into a professional (through the escalating requirements of education, certification, and licensure). In the transition from paraprofessional to professional, recovering counselors took on the trappings of power and authority and forged traditional service relationships in which the “new profession” was protected but the client was abandoned. We conveyed that separation in a thousand subtle ways: our gatekeepers (secretaries), the required rituals of access, our titles, our dress, our desks, our posted degrees and certificates, our office bookshelves, our language, our use of diagnoses and labels, our papers and protocols—even separate bathrooms. We entered the field speaking the “language of the heart” and shed that language in exchange for a professional argot that elevated our status but distanced us from those we were pledged to serve (Author, excerpt from personal journal).

⁵²¹ Talbott, J. A., Ross, A. M., Skerrett, A. F., Curry, M. D., Marcus, S. I., Theodorou, H., & Smith, B. J. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, 130, 805-808.

⁵²² McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield: IL: Charles C. Thomas Publisher.

This raises the question of whether we “train out the best qualities and characteristics”⁵²³ of those entering the field. There is a clear trend toward decreased face-to-face time between counselor and client, greater task orientation in the counseling process, and a decreased focus on issues that have a direct nexus to long-term recovery outcomes.⁵²⁴ In this context, distinctions that once existed between the features of recovering counselors and those of counselors without addiction histories may well have dissipated. The same may well be said for recovering people working as physicians, nurses, psychologists, and social workers in addiction treatment.

Why are the service needs and recovery supports being addressed within the framework of P-BRSS not addressed by the addiction counselor? The progressive erosion of recovery representation within the addiction counseling field and the new professional etiquette of addiction counseling diminished the early peer qualities of the service relationship. As the addiction counselor’s role came to resemble the roles that had preceded it (psychologist, social worker, mental health counselor), conditions were set for the emergence of a new role that recaptured these peer qualities. P-BRSS constitute, not a new chapter in the history of addiction recovery, but an effort to retrieve something of past value that was lost.⁵²⁵

This discussion is intended to demean neither the process of professionalization nor those, including the author, who invested most of their careers in this goal. But it is intended to raise the question of whether our focus on the professional and administrative structures and processes established to ensure the quality of addiction treatment have diverted our eyes from the ultimate outcome of care (recovery). The message here for addictions professionals is that one must resist and regularly mend the disconnection between what we are doing and why we are doing it. There are service professionals who will be allies in this effort to renew addiction treatment and to create more authentic and more person/family-centered service relationships. The ultimate goal of professional care is long-term recovery. Professional structures of helping must be constantly refocused on that goal. Adding P-BRSS as a band-aid on addiction treatment as a system of care will not, by itself, mend this breach.⁵²⁶

The validity of the work of recovering persons and of peer-based support lends credence to the community of professionals who want more than the rigid boundaries that regulation and habit of mind have imposed. There are many professionals who are encouraged by what peer support

⁵²³ Wolf, S. (1974/1975). Counseling—for better or for worse. *Alcohol Health and Research World, Winter*, 27-29.

⁵²⁴ Toriello, P.J. & Strohmer, D.C. (2005). Addictions counselors’ credibility: The impact of interactional styles, recovery status, and nonverbal behavior. *Journal of Addictions and Offender Counseling*, 25(1), 43-57. White, W., Scott, C., Dennis, M., & Boyle, M. (2005). It’s time to stop kicking people out of addiction treatment. *Counselor*, 6(2), 12-25.

⁵²⁵ White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor*, 5(6), 20-22.

⁵²⁶ Special thanks to David Dan for our discussion of these points.

*services are adding to the recovery process and who are using the lessons from peer support to renew their own professional service work.*⁵²⁷

DEMOGRAPHIC PROFILE OF COUNSELORS IN RECOVERY

There are no national workforce studies that reveal the demographics of recovering and nonrecovering counselors working in addiction treatment; however, some early work suggests potentially important differences. LoSciuto and colleagues⁵²⁸ reviewed staffing patterns at five drug addiction treatment programs in the 1970s and found that ex-addict counselors were more likely than professional counselors to be male (60% vs. 48%) and older (39 vs. 29), and less likely to be Caucasian (22.6% vs. 67.7%). While profound changes have occurred in the composition of the addiction treatment workforce,⁵²⁹ recent studies offer no profile of recovering people working in the field and no clear sense of how that profile has changed over the past 40 years.

The profile of recovering people entering the addiction treatment field does have relevance to larger workforce development issues. Women now make up from 50 to 70% of the addiction treatment workforce, although 68% of clients admitted to addiction treatment are men.⁵³⁰ Similarly, less than 10% of the addiction treatment workforce is non-white, while 43% of clients admitted to addiction treatment are people of color.⁵³¹ As the field of addiction treatment has become a less desirable and less financially viable occupational choice for men, recruitment of men in recovery may be an essential strategy for developing some degree of match between the gender of clients and service providers. Recruitment of recovering people of color may achieve a similar goal in terms of ethnic and cultural representation.

PRIOR TREATMENT/RECOVERY EXPERIENCE OF COUNSELORS IN RECOVERY

There has been no systematic review of the personal treatment and recovery histories of people working as addiction counselors. Little is known of their prior treatment experience (the type, number, and duration of past treatment episodes), the length of stable recovery prior to beginning work as an addictions

⁵²⁷ Personal communication with David Dan, December 2008.

⁵²⁸ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

⁵²⁹ Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment. Retrieved from <http://www.oas.samhsa.gov/TEDS2k6highlights/Tbl2b.htm>.

⁵³⁰ Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment.

⁵³¹ Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, 24(1), 51-7.

counselor, recovery pathways (religious, spiritual, secular), or past/present involvement in recovery mutual-aid groups. Only one study from the 1970s was found that touched on these issues—a study noting that recovering counselors in the drug abuse programs studied had spent a median length of 22 months in treatment within a variety of programs (drug free, chemically supported detoxification, and methadone maintenance).⁵³²

PRE-SERVICE EDUCATIONAL FUNCTIONING OF COUNSELORS IN RECOVERY

Koch and Blanco⁵³³ conducted a study that compared the academic performance of two groups of students in an “Alcohol, Drugs and Society” course. The groups compared were 1) general study students and 2) students, an unreported number of whom were in recovery, who were preparing to become addiction counselors. There were no differences in academic performance between these counselors-in-training and others taking the course. Koch and Blanco concluded, “There is no evidence that pre-professionals get caught up in a paradigm shift which creates academic problems for them...” (p. 89).⁵³⁴ This confirms findings of an earlier evaluation of an alcoholism counselor training program that found no differences in cognitive learning gains between non-alcoholics and recovering alcoholics preparing to be alcoholism counselors.⁵³⁵ Similarly, performance on certification tests has been linked to educational levels but not to recovery status.⁵³⁶

EDUCATIONAL LEVELS OF RECOVERING PEOPLE WORKING AS ADDICTION COUNSELORS

Recovering counselors as a group have fewer years of educational training compared to counselors without addiction/recovery backgrounds, but the degree of difference in levels of education has narrowed since the 1970s.⁵³⁷ Two

⁵³² LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

⁵³³ Koch, J.R. & Blanco, J.D. (2001). Studying “alcohol, drugs, and society” from a sociological perspective: Comparing the academic performance of pre-professionals in addiction studies with students majoring in other disciplines. *Alcoholism Treatment Quarterly*, 19(4), 81-90.

⁵³⁴ Koch, J.R. & Blanco, J.D. (2001). Studying “alcohol, drugs, and society” from a sociological perspective: Comparing the academic performance of pre-professionals in addiction studies with students majoring in other disciplines. *Alcoholism Treatment Quarterly*, 19(4), 81-90.

⁵³⁵ Gideon, W.L., Little, A.S., & Martin, D.W. (1980). Evaluation of a training program for certified alcoholism counselors. *Journal of Studies on Alcohol*, 41, 8-20.

⁵³⁶ Arneson, A.H., Ruben, D.H., & Husain, S. (1984). Credentialing of substance abuse counselors: A field evaluation. *Journal of Drug Education*, 14(4), 297-306.

⁵³⁷ Bokos, P. J. (1974). Education and training for drug abuse paraprofessional staff. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1037-1040). Cambridge, MA: Schenkman. McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, 4(1),

surveys conducted in the 2003-2004 period are revealing. The first found that more than 70% of addiction counselors have some college education, with 29% reporting a bachelor's degree, 27% a master's degree, and 5% a doctorate.⁵³⁸ The second survey found that 79.9% of addiction treatment professionals have at least a bachelor's degree and 48.6% have a master's degree.⁵³⁹ The percentage of recovering counselors today who have college or advanced degrees has not been reported. The increased educational requirements for addiction counselor certification and licensure has contributed to the shrinking recovery representation in the field and the likely increase in the educational credentials of people in recovery who today work as addiction counselors.

While educational levels are increasing among addiction counselors, only 55% of states require a bachelor's degree to work as an addictions counselor. By contrast, 98% of states require a master's degree to work as a mental health counselor.⁵⁴⁰ The superiority of the allied health professional model (with its reliance on educational preparation) over the apprenticeship model (which has an emphasis on experiential preparation and mentorship by a professional elder) has yet to be established in the addiction treatment and recovery support arenas. (See later discussion on recovery outcomes.)

CERTIFICATION, LICENSURE, AND CLINICAL EFFECTIVENESS

Many factors led to the drive for certification and professional licensure of “alcoholism counselors” and “drug abuse counselors” during the pre-professional years of addiction treatment. Many of these focused on potential gains for:

- the maturing field (buttressing the field's claim to cultural ownership of AOD problems),
- local treatment organizations (achieving organizational status among allied service organizations and referral sources, compliance with new accreditation standards, service reimbursement from third-party payors, and reduced organizational liability),
- addiction counseling as a profession (achieving professional status and protecting newly acquired professional turf), and

43-60. Stöffelmayr, B.E., Mavis, B.E., & Kasim, R.M. (1998). Substance abuse treatment staff: Recovery status and approaches to treatment. *Journal of Drug Education*, 28(2), 135-145.

⁵³⁸ Libretto S.V., Weil, J., Nemes, S., Linder, N.C., & Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs*, 36(4), 489-97.

⁵³⁹ Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, 24(1), 51-7.

⁵⁴⁰ Kerwin, M.E., Walker-Smith, K., & Kirby, K.C. (2006). Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment*, 30(3), 173-81.

- the addiction counselor (acquiring occupational status, a legitimized role within multidisciplinary teams, professional confidence, and enhanced income potential and career opportunities).⁵⁴¹

These larger interests were nested within the proposition that credentialing addiction counselors would protect and benefit consumers of addiction treatment.

College-based and independent preparatory addiction studies programs, clinical training programs, and addiction counselor certification programs became major sub-industries within the larger industrial economy of addiction treatment. The goal was to professionalize the paraprofessional recovering counselor or replace that counselor with professionals credentialed by education. In spite of the efforts toward this goal over nearly four decades, the proportion of addiction counselors who are certified or licensed varies across states from 45% to 72%.⁵⁴² In 2004, there were more than 130,000 direct service staff working within addiction treatment programs in the United States, and of those who filled counseling roles, only half were certified by one of the 66 organizations that credential counselors.⁵⁴³

Surprisingly, there is a marked lack of scientific evidence that counselor education, certification, or licensure have elevated the long-term recovery outcomes of consumers of specialty-sector addiction treatment. Studies to-date have not found differences in effectiveness between degreed and non-degreed addiction counselors,⁵⁴⁴ and no studies were found in this review that specifically evaluated whether clients of certified or licensed counselors achieve better recovery outcomes than clients of counselors who are not certified or licensed. What little evidence we do have confirms considerable differences across counselors in clients' short-term (treatment engagement and retention) and long-term (post-treatment recovery status and level of global health and functioning) outcomes, but these are unrelated to such factors as age, gender, race, education, or certification status.⁵⁴⁵ Only a minority of studies have found these

⁵⁴¹ Amodeo, M. (2006). Securing an equal role for substance abuse counselors: A commentary on Kerwin, Walker-Smith, and Kirby. *Journal of Substance Abuse Treatment*, 30, 169-170.

⁵⁴² Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment.

⁵⁴³ Libretto S.V., Weil, J., Nemes, S., Linder, N.C., & Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs*, 36(4), 489-97.

⁵⁴⁴ Valle, S.K. (1977). Relative effectiveness of degreed and non-degreed alcoholism counselors. *Maryland State Medical Journal*, 26(11), 12-14. Gideon, W.L., Little, A.S., & Martin, D.W. (1980). Evaluation of a training program for certified alcoholism counselors. *Journal of Studies on Alcohol*, 41, 8-20.

⁵⁴⁵ Connors, G.H., DiClemente, C.C., Dermon, K.H., Kadden, R., Carroll, K.M., & Frone, M.R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol*, 61, 139-149; Mendelsohn, G.A. & Geller, M.H. (1965). Structure of client attitudes toward counseling and their relation to client-counselor similarity. *Journal of Consulting Psychology*, 29, 63-72. Sterling, R.C., Gottheil, E., Weinstein, S.P. & Serota, R. (2002). Therapist/patient race and sex matching: Treatment retention and 9-month follow-up outcome. *Addiction*, 93, 1043-1050. Gottheil, E., Sterling, R.C., Weinstein, S.P., & Kurtz, J.W. (1994). Therapist/patient matching and early treatment drop-out. *Journal of Addictive Diseases*, 13(4), 169-76.

factors of significance to intermediate outcomes,⁵⁴⁶ and no well designed studies were located that draw a clear connection between enhanced recovery rates and counselor education or certification. (See later discussion on recovery status of counselors and client recovery outcomes.)

COMPENSATION OF RECOVERING COUNSELORS VERSUS COUNSELORS WITHOUT A HISTORY OF ADDICTION

Administrators of addiction treatment programs report no perceived differences between the effectiveness of recovering counselors and that of counselors without a history of addiction,⁵⁴⁷ but they pay the former less for comparable work. Olmstead and colleagues⁵⁴⁸ analyzed salary data within the 2002-2003 National Treatment Center Study and found that, when other factors such as education, years of experience, and certification/licensure are controlled, recovering counselors receive \$1,000-\$2,580 per year lower salary compensation than do counselors who do not have a history of addiction. They theorize that this lower compensation is related to two factors: 1) fewer job alternatives for recovering counselors and 2) the willingness of recovering counselors to work for less pay in jobs to which they feel “called.” This author would suggest a third possibility: that lower compensation for equivalently educated recovering counselors reflects the unrecognized internalization of social stigma within the addiction treatment field.

PERSONALITY CHARACTERISTICS OF RECOVERING ADDICTION COUNSELORS

Studies of the personalities of recovering men and women working as addiction counselors reveal few differences from counselors without addiction/recovery backgrounds.⁵⁴⁹ Shipko and Stout (1992) conducted a study

⁵⁴⁶Meir, P.S., Donmall, M.C., Barrowclough, C., McElduffin P., & Heller, R.F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction*, 100, 500-511.
Siqueland, L., Crits-Christoph, P., Barber, J.P., Butler, S.F., Thase, M., Najavits, L., et al. (2000). The role of therapist characteristics in training cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. *Journal of Psychotherapy Practice Research*, 9(3), 123-130.

⁵⁴⁷Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73, 596-603.

⁵⁴⁸Olmstead, T.A., Johanson, J.A., Roman, P.M., & Sinclair, J.L. (2005). What are the correlates of substance abuse counselor salaries? *Journal of Substance Abuse Treatment*, 29, 181-189.
Olmstead, T. (2007). Why are recovering counselors paid less? *Substance Abuse*, 28(1), 31-44.

⁵⁴⁹Hoffman, H. & Miner, B.B. (1973). Personality of alcoholics who became counselors. *Psychological Reports*, 33, 878. Hoffmann, H. & Bonyng, E.R. (1977). Personalities of female alcoholics who became counselors. *Psychological Reports*, 41(1), 37-38.

of personality characteristics of addiction counselors that included such issues as capacity for empathy, flexibility, and tolerance. They concluded that "...there were no significant differences between the recovering alcohol counselors and non-alcoholic counselors..."⁵⁵⁰ The general conclusion of these studies is that counselor effectiveness is related to particular traits that are not linked to recovery or non-recovery status.⁵⁵¹ The only exception to these general findings is a 1975 study by Jansen and Hoffman.⁵⁵² Their study concluded that some enduring traits of "addictive personalities" remained after recovering alcoholics had been trained as alcoholism counselors, but drew no conclusions as to whether such traits hindered or aided effective addiction counseling.

BELIEFS AND ATTITUDES OF RECOVERING ADDICTION COUNSELORS

Numerous studies have been conducted—most in the 1970s—to evaluate differences in the beliefs and attitudes of addiction counselors based on the presence or absence of personal addiction recovery. LoSciuto and colleagues⁵⁵³ found no substantial differences based on recovery status in counselors' views on such issues as the etiology of addiction or factors related to treatment success.

*The attitudinal similarity of the three counselor groups [professional counselors, ex-addict counselors, and non-ex-addict paraprofessionals], regardless of education, work, and life experience, and regardless of attitudinal area investigated, is most striking.*⁵⁵⁴

In 1987, McGovern and Armstrong⁵⁵⁵ conducted a state (Texas) and national (NAADAC membership) survey of addiction counselors that compared the characteristics of recovering and non-alcoholic counselors. Although recovering counselors were more likely to be male, certified, and less well educated than non-alcoholic counselors, the two groups expressed similar attitudes toward treatment-related issues. Like the McGovern and Anderson study, most early studies reveal few if any differences by counselor recovery

⁵⁵⁰ Shipko, J. & Stout, C. (1992). A comparison of the personality characteristics between the recovering alcoholic and non-alcoholic counselor. *Alcoholism Treatment Quarterly*, 9, 207-214, quote from page 211.

⁵⁵¹ Covner, B. (1969). Screening volunteer alcoholism counselors. *Quarterly Journal of Studies on Alcohol*, 30, 420-425.

⁵⁵² Jansen, D.G. & Hoffman, H. (1975). MMPI scores of counselors on alcoholism prior to and after training. *Journal of Consulting and Clinical Psychology*, 43, 271.

⁵⁵³ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

⁵⁵⁴ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

⁵⁵⁵ McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, 4(1), 43-60.

status on perceptions of drinking behaviors or beliefs about addiction and addiction treatment.⁵⁵⁶ LoSciuto, Aiken, Ausetts, and Brown (1984) note this central finding:

*The similarities in responses...of counselors are much more impressive than are the differences...The groups conceive of the etiology of drug abuse, the nature of drug abusers, the factors critical for drug treatment and the lasting outcomes of treatment as essentially the same....*⁵⁵⁷

But they did find some qualitative differences worth noting:

*While clients of the three groups viewed their counselors as equally able to understand them and were equally confident in their counselors, the clients of ex-addict counselors saw their counselors as more knowledgeable about critical issues of drugs and the street scene, were more willing to bring personal problems to their counselors, and expected and desired more participation from their counselor in both counseling-related and personal problems.*⁵⁵⁸

LoSciuto, Aiken, Ausetts, and Brown (1984)⁵⁵⁹ also found that ex-addict counselors were more positive about their clients' prospects for recovery.

Other studies of counselor beliefs and attitudes have contradictory findings. Some conclude that recovered counselors more strongly embrace the conception of addiction as a disease⁵⁶⁰ and abstinence as a treatment goal (and are less supportive of a moderation goal) than counselors without a history of

⁵⁵⁶ Humphreys, K., Noke, J.M., & Moos, R.H. (1996). Recovering substance abuse staff members' beliefs about addiction. *Journal of Substance Abuse Treatment*, 13, 75-78. Leavy, R.L. (1991). Alcoholism counselors' perceptions of problem drinking. *Alcoholism Treatment Quarterly*, 8(3), 47-55. Roach, E.F. (2005). Counselor prejudice, history of recovery, and client race/gender as predictors of counselor assessments of substance-abusing clients, Dissertation, Fordham University. *Dissertation Abstracts International*, 66(03B), 1733. Skuja, A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Drug and Alcohol Dependence*, 8(1), 61-68.

⁵⁵⁷ LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, 19(3), 233-252, quotation from p. 249.

⁵⁵⁸ LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, 19(3), 233-252, quotation from p. 234.

⁵⁵⁹ LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, 19(3), 233-252.

⁵⁶⁰ Bennett, N. & Kelly, L.S. (1987). Assessing the acceptance of the disease concept of alcoholism among EAP practitioners. *Journal of Drug Issues*, 17, 281-289. Ferneau, E. & Paine, H. (1972). Attitudes regarding alcoholism: The volunteer alcoholism clinic counselor. *British Journal of Addiction*, 67, 235-238. Schaler, J.A. (1995). The Addiction Belief Scale. *International Journal of the Addictions*, 30, 117-134.

addiction.⁵⁶¹ Other studies conclude that beliefs of addiction counselors are shaped primarily by education rather than recovery status⁵⁶² and that recovering counselors use a broader range of techniques and embrace a broader range of treatment goals than do counselors not in recovery.⁵⁶³ Crabb and Linton⁵⁶⁴ found that addiction counselors in recovery were no more likely than counselors not in recovery to believe that alcoholics could not learn moderate drinking.⁵⁶⁵ Equally striking in this study was the finding that counselors in recovery held the most non-traditional beliefs and were more likely to change their belief systems about addiction, treatment, and recovery over the course of their counseling careers—findings confirmed in other studies.⁵⁶⁶ There is a need to confront stereotypes in this arena. Humphreys, Noke, and Moos conducted a study of counselor attitudes and concluded:

*Because recovering staff have a varied educational background and come from diverse disciplines, treatment professionals who hire, supervise and work with recovering staff should not assume that being in recovery necessarily implies a particular perspective on treatment. The regression equations demonstrate that recovery status is a less consistent predictor of beliefs than are other factors.*⁵⁶⁷

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- ⁵⁶¹ Skuja, A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Drug and Alcohol Dependence*, 8(1), 61-68. Wallace, S.E. (1994). Attitudes and beliefs of certified substance abuse counselors. *Dissertation Abstracts International*, 55(3), 1226-B.
- ⁵⁶² Kolpack, R. (1992). Credentialing alcoholism counselors. *Alcoholism Treatment Quarterly*, 9, 97-112. Leavy, R.L. (1991). Alcoholism counselors' perceptions of problem drinking. *Alcoholism Treatment Quarterly*, 8(3), 47-55.
- ⁵⁶³ Stöffelmayr, B.E., Mavis, B.E., & Kasim, R.M. (1998). Substance abuse treatment staff: Recovery status and approaches to treatment. *Journal of Drug Education*, 28(2), 135-145. Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, 31(2), 121-127.
- ⁵⁶⁴ Crab, A.C. & Linton, J.M. (2007). A qualitative study of recovering and nonrecovering substance abuse counselors' belief systems. *Journal of Addictions and Offender Counseling*, 28(1), 4-20.
- ⁵⁶⁵ This perception does differ between recovery alcoholic counselors and professional social workers employed outside of addiction treatment, with the social workers perceiving greater likelihood of successful moderation of drinking by alcoholics. Chambers, P.R. (1982). An examination of paraprofessional recovering alcoholic counselor variables and their effect on therapeutic outcome. Dissertation, United States International University. *Dissertation Abstracts International*, 43(02B), 0518.
- ⁵⁶⁶ Sorensen, K.L. (1998). Addiction counselor trainees' receptivity to non-traditional information about alcoholism. *Dissertation Abstracts International*, 59, Z5055. Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, 31(2), 121-127.
- ⁵⁶⁷ Humphreys, K., Noke, J.M., & Moos, R.H. (1996). Recovering substance abuse staff members' beliefs about addiction. *Journal of Substance Abuse Treatment*, 13, 75-78, quotation from page 77.

Humphreys was even more explicit on this point in his 2004 review: "When level of education is taken into account, recovering staff are no more likely to endorse a 12-Step style disease model than non-recovering staff...."⁵⁶⁸

Thombs and Osborn (2001)⁵⁶⁹ used cluster analysis to create a typology of three different clinical orientations of addiction counselors: a uniform group that minimized client differences, a multiform group that embraced diverse beliefs about addiction and recovery, and a client-directed group that recognized client heterogeneity and the high need for individual counseling. Their conclusions are consistent with Humphreys:

*The findings of this study challenge the descriptions, or perhaps the stereotype, of chemical dependency counselors as a monolithic group strident in its advocacy of the disease model and closed to other treatment options. It is noteworthy that counselors in recovery were not concentrated in any particular cluster.*⁵⁷⁰

Existing studies have tended to focus on dichotomous comparisons between recovering counselors and counselors with no history of addiction. Further studies of intragroup differences among recovering counselors and recovering people filling other roles will likely underscore the lack of homogeneity and in fact the rich diversity that exists among addiction counselors in recovery. It appears that the image of the recovering counselor as a person who is resistant to new knowledge and clinical practices is a stereotype lacking factual foundation.⁵⁷¹

Treatment setting also exerts an influence on the attitudes and beliefs of recovering counselors and counselors without history of addiction. Berger-Gross and Lisman⁵⁷² compared the attitudes toward alcoholism of paraprofessionals working in a state hospital with those of paraprofessionals working in a detoxification center (85% of each group was in recovery). Attitudes varied by setting, with those paraprofessionals working in the detoxification center exhibiting far less tolerant attitudes. Brown, Jansen, and Bass⁵⁷³ conducted a study of attitudes regarding the use of methadone in the treatment of heroin addiction among three groups of staff: ex-addict counselors, ex-addict counselors who were maintained on methadone, and non-addict counselors. All

⁵⁶⁸ Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press, quote from page 175.

⁵⁶⁹ Thombs, D.L. & Osborn, C.J. (2001). A cluster analytic study of clinical orientations among chemical dependency counselors. *Journal of Counseling and Development*, 79, 450-458.

⁵⁷⁰ Thombs, D.L. & Osborn, C.J. (2001). A cluster analytic study of clinical orientations among chemical dependency counselors. *Journal of Counseling and Development*, 79, 450-458.

⁵⁷¹ Campbell, T. C., Catlin, L. A., & Melchert, T. P. (2003). Alcohol and other drug abuse counselors' attitudes and resources for integrating research and practice. *Journal of Drug Education*, 33(3), 307-323.

⁵⁷² Berger-Gross, V. & Lisman, S. (1979). Attitudes of paraprofessionals toward alcoholism: Setting effects. *Journal of Studies on Alcohol*, 40, 514-517.

⁵⁷³ Brown, B.S., Jansen, D.R., & Bass, U.F. (1974). Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction. *American Journal of Psychiatry*, 131(2), 215-219.

three groups were ambivalent about methadone and expressed attitudes suggesting that the use of methadone reflects “a certain lack of personal integrity on the part of those clients as compared with clients who have become abstinent.”⁵⁷⁴

Brown and colleagues expressed concern that such attitudes could be conveyed to clients in methadone treatment and exert pressure for premature termination of treatment. The legitimacy of their concern was validated by later studies related to the shame and stigma (“dirty little secret”) experienced by those taking methadone for treatment of opiate addiction.⁵⁷⁵ Subsequent studies also confirmed continuation of an abstinence bias (a view that methadone should be time limited and that recovery begins only when methadone treatment is terminated) among frontline MMT counselors and nurses⁵⁷⁶ and the link between abstinence orientation and shorter lengths stay in MMT.⁵⁷⁷ This is of particular concern given studies confirming that MMT outcomes improve when a minimal threshold of at least one year has been reached⁵⁷⁸ and that dropout rates are linked to clients’ misconceptions about methadone and negative attitudes toward MMT.⁵⁷⁹ Staff pressure to move toward termination of methadone maintenance is also of concern due to the high post-discharge relapse rates (70%+) and increased death rates linked to the loss of drug tolerance.⁵⁸⁰

⁵⁷⁴ Brown, B.S., Jansen, D.R., & Bass, U.F. (1974). Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction. *American Journal of Psychiatry*, 131(2), 215-219, quote from page 218.

⁵⁷⁵ Murphy, S. & Irwin, J. (1992). “Living with the dirty secret”: Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs*, 24(3), 257-264. Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1988). Differences among treatment clinic types in attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, 176, 714-718. White, W. & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor*, 4(5), 58-63.

⁵⁷⁶ Caplehorn, J. R., Hartel, D. M., & Irwig, L. (1997). Measuring and comparing the attitudes and beliefs of staff working in New York methadone maintenance clinics. *Substance Use & Misuse*, 32(4), 399-413.

⁵⁷⁷ Caplehorn, J. R., Lumley, T. S., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence*, 52, 57-61.

⁵⁷⁸ Simpson, D.D. & Joe, G.W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, 27, 99-121.

⁵⁷⁹ Kayman, D.J., Goldstein, M. F., Deren, S., & Rosenblum, A. (2006). Predicting treatment retention with a brief “Opinions about methadone” scale. *Journal of Psychoactive Drugs*, 38(1), 93-100.

⁵⁸⁰ Coviello, D.M., Zanis, D.A., Wesnoski, S.A., & Alterman, A.I. (2006). The effectiveness of outreach case management in re-enrolling discharged methadone patients. *Drug and Alcohol Dependence*, 85, 56-65. Strang, J., McCambridge, J., Best, D., Beswick, T., Bearn, J., Rees, S., et al. (2003). Loss of tolerance and overdose mortality after inpatient opiate detoxification: Follow up study. *British Medical Journal*, 326, 959-960. Zanis, D.A. & Woody, G.E. (1998). One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence*, 52(3), 257-260.

ATTITUDES AND BEHAVIORS OF RECOVERING COUNSELORS RELATED TO EVIDENCE-BASED PRACTICES

In discussing evidence-based practices in addiction treatment, one sometimes hears the comment that counselors in recovery resist new evidence-based practices in favor of traditional models of treatment. To further explore the character and performance of the recovering counselor, we will test this proposition by reviewing studies that illuminate whether such resistance is a reality or a myth. The major findings of counselor attitudes toward evidence-based practices reveal the following:

- University and medical center research sites have a far lower representation of recovering staff than community-based sites, which might influence study findings and transfer of knowledge from research to community service sites.⁵⁸¹
- The addictions field has promoted advanced educational and certification requirements regardless of recovery status.⁵⁸²
- Few differences exist in theoretical orientation or use of treatment techniques as a function of recovery status;⁵⁸³ “12-Step orientation” is often considered a proxy for recovery status among addiction counselors, but such orientation is related more to the factors of education and years of clinical experience than to recovery status.⁵⁸⁴ “This underscores the need to consider traditional 12-Step clinicians as complex, flexible and heterogeneous and neither predictable nor closed-minded to other behavioral approaches.”⁵⁸⁵

⁵⁸¹ Arfken, C.L., Agius, E., Dickson, M.W., Anderson, H.L., & Hegedus, A.M. (2005). Clinicians’ beliefs and awareness of substance abuse treatments in research and non-research affiliated programs. *Journal of Drug Issues*, 35, 547-558.

⁵⁸² Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., McSherry, T., et al. (2002). Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers. *Journal of Substance Abuse Treatment*, 23, 309-318.

⁵⁸³ Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., McSherry, T., et al. (2002). Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers. *Journal of Substance Abuse Treatment*, 23, 309-318.

⁵⁸⁴ Forman, R.F., Bovasso, G., & Woody, G. (2001). Staff beliefs about addiction treatment. *Journal of Substance Abuse Treatment*, 21, 1-9. Humphreys, K., Noke, J.M., & Moos, R.H. (1996). Recovering substance abuse staff members’ beliefs and about addiction. *Journal of Substance Abuse Treatment*, 13, 75-78. Knudsen, H.K., Ducharme, L.J., Roman, P.M., & Link, T. (2005). Buprenorphine diffusion: The attitudes of substance abuse treatment counselors. *Journal of Substance Abuse Treatment*, 29, 95-106. Roman, P.M. & Johnson, J.A. (2002). Adoption and implementation of new technologies in substance abuse treatment. *Journal of Substance Abuse*, 22, 211-218.

⁵⁸⁵ McGovern, M.P., Fox, T.S., Xie, H., & Drake, R.E. (2004). A survey of clinical practices and readiness to adopt evidence-based practices: Dissemination research in an addiction treatment system. *Journal of Substance Abuse Treatment*, 26, 305-312.

- Attitudes toward evidence-based psychosocial interventions such as contingency management do not differ by recovery status alone.⁵⁸⁶
- Counselor attitudes concerning the acceptability and effectiveness of buprenorphine in the treatment of opiate dependency and naltrexone in the treatment of alcohol abuse and dependence do not vary by counselor recovery status,⁵⁸⁷ but counselors in recovery express more negative attitudes toward the use of ibogaine in opioid dependency than do counselors not in recovery.⁵⁸⁸
- Counselor receptivity to the use of medications in addiction treatment is a function of education, training, and certification/licensure, rather than recovery status.⁵⁸⁹
- There is no direct linkage between counselor recovery status and support for or resistance to the implementation of evidence-based practices in addiction treatment.⁵⁹⁰

The studies reviewed here challenge the portrayal of addiction counselors in recovery as a monolithic group that supports a single pathway model of addiction, treatment, and recovery and resists the acquisition of new knowledge

⁵⁸⁶ Kirby, K. C., Benishek, L. A., Dugosh, K. L., & Kerwin, M. E. (2006). Substance abuse treatment providers' beliefs and objections regarding contingency management: Implications for dissemination. *Journal of Substance Abuse Treatment*, 85, 19-27.

⁵⁸⁷ Knudsen, H.K., Roman, P.M., Ducharme, L.J., & Johnson, J.A. (2005). Organizational predictors of pharmacological innovation adoption: The case of disulfiram. *Journal of Drug Issues*, 35, 559-573. Thomas, S.E. & Miller, P.M. (2006). Knowledge and attitudes about pharmacotherapy for alcoholism: A survey of counselors and administrators in community-based addiction treatment centres. *Alcohol and Alcoholism*, 42, 113-118.

⁵⁸⁸ There are program differences that distinguish openness to naltrexone adoption, with treatment programs based on a 12-Step philosophy less inclined to use naltrexone, and physicians in recovery are less inclined to prescribe Naltrexone. Oser, C.B. & Roman, P.M. (2007). A categorical typology of naltrexone-adopting private substance abuse treatment centers. *Journal of Substance Abuse Treatment*, 34(4), 433-442. Thomas, C.P., Wallack, S.S., Lee, S., McCarty, D., & Swift, R. (2003). *Journal of Substance Abuse Treatment*, 24, 1-11. Rieckmann, T., Daley, M., Fuller, B.E., Thomas, C.P., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications for treatment of opioid dependence. *Journal of Substance Abuse Treatment*, 32, 207-215.

⁵⁸⁹ Fuller, B.E., Rieckmaan, T., McCarty, D., Smith, K.W., & Levine, H. (2005). Adoption of naltrexone to treat alcohol dependence. *Journal of Substance Abuse Treatment*, 28, 273-280. Knudsen, H.K., Roman, P.M., Ducharme, L.J., & Johnson, J.A. (2005). Organizational predictors of pharmacological innovation adoption: The case of disulfiram. *Journal of Drug Issues*, 35, 559-573.

⁵⁹⁰ Kirby, K. C., Benishek, L. A., Dugosh, K. L., & Kerwin, M. E. (2006). Substance abuse treatment providers' beliefs and objections regarding contingency management: Implications for dissemination. *Journal of Substance Abuse Treatment*, 85, 19-27. Knudsen, H.K. & Roman, P.M. (2004). Modeling the use of innovations in private treatment organizations: The role of absorptive capacity. *Journal of Substance Abuse Treatment*, 26, 353-361.

and skills.⁵⁹¹ The addiction treatment workforce scores high on readiness to adopt new counseling techniques that would improve recovery outcomes.⁵⁹²

ROLE PERCEPTIONS OF RECOVERING ADDICTION COUNSELORS

In the 1970s, Kozel and Brown⁵⁹³ conducted a study of ex-addicts' and non-addict counselors' perceptions of their roles as counselors. The two groups shared a common vision of their role. The only noted difference was that ex-addicts perceived the ideal counseling role as involving greater amounts of time spent in community education, counseling in the community, and socializing with clients. Aiken and colleagues confirmed this finding a decade later.⁵⁹⁴

RECOVERY STATUS AND CLIENT PERCEPTION OF CREDIBILITY AND EFFECTIVENESS

Ball and colleagues⁵⁹⁵ asked addicted clients in treatment to rate the degree of helpfulness of treatment staff. Forty-two percent of professional counselors were rated as helpful, while 60% of ex-addict counselors were rated as helpful. Another early study on counselor credibility focused on the addicts' ratings of various sources of information about drugs. Sinnett and colleagues⁵⁹⁶ found that addicts felt that their own experience and that of ex-addicts (source ranking of 1 and 2) were far more credible sources of information than scientific journals (source ranking of 19) or psychologists, psychiatrists, or social workers (source rankings of 23, 25, and 30 respectively). LoSciuto and colleagues⁵⁹⁷ found that clients favored ex-addicts on their knowledge of street drugs, but that

⁵⁹¹ Thombs, D.L. & Osborn, C.J. (2001). A cluster analytic study of clinical orientations among chemical dependency counselors. *Journal of Counseling and Development*, 79, 450-458.

⁵⁹² Toriello, P.J., Roahen-Harrison, S., Rice, J., Ager, R., Morse, E.V., Morse, P., et al. (2005). The relationship between addictions counselors' clinical orientations and their readiness to change counseling techniques. *Journal of Addictive Diseases*, 24(1)Supplement, 75-92.

⁵⁹³ Kozel, N.J. & Brown, B.S. (1973). The counselor role as seen by ex-addict counselors, nonaddict counselors and significant others. *Journal of Consulting and Clinical Psychology*, 41, 315.

⁵⁹⁴ Aiken, L., LoSciuto, L., Ausetts, M., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Diverse routes to the same role. *International Journal of Addictions*, 19(2), 153-73.

⁵⁹⁵ Ball, J.C., Graff, H., & Sheehan, J.J., Jr. (1974). The heroin addict's view of methadone maintenance. *British Journal of the Addictions*, 69(1), 89-95.

⁵⁹⁶ Sinnett, E.R., Hagen K., & Harvey, W.M. (1975). Credibility of source of information about drugs to heroin addicts. *Psychological Reports*, 37(3), 1239-1242. Sinnet, E.R., Press, A., Bates, R.A., & Harvey, W.M. (1975). Credibility of sources of information about drugs. *Psychological Reports*, 36, 299-309.

⁵⁹⁷ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

recovering counselors and counselors without a history of addiction achieved similarly high marks on other aspects of the counseling relationship.

Later studies of client perceptions of counselors concerning such factors as empathy, expertness, trustworthiness, and attractiveness do not generally show significant differences in these perceptions based on the recovery status of the counselor.⁵⁹⁸ Berzins and Ross⁵⁹⁹ looked at the helping preferences of 50 hospitalized female opiate addicts. While professionals and ex-addicts exerted similar attractiveness, patients with more severe addictions expressed preference for ex-addict helpers, and those with milder problem severity expressed preference for professionals. As one of the few studies that factored in problem severity, this study suggests that recovering helpers may have a special role engaging people with the most severe addiction problems and serving as a bridge for connection to professionals and the larger society they represent.

Professional training, regardless of recovery status, increases credibility in the eyes of clients.⁶⁰⁰ But at least one study⁶⁰¹ found that recovering counselors were less likely than counselors without a history of addiction to believe they needed addiction education and training. When clients are asked to rate their perceptions of the value of ex-addict counselors, African American counselors and clients rate such value considerably higher than do other ethnic groups.⁶⁰² Savage and Stickles⁶⁰³ compared the perceptions of three groups concerning whether recovering counselors or counselors without a history of

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- ⁵⁹⁸ Aiken, L.S. & LoSciuto, L.A. (1985). Ex-addict versus non-addict counselors' knowledge of clients' drug use. *International Journal of the Addictions*, 20, 417-433. Ellis, K.P. (1995). Client perception of the therapist in drug treatment as a function of interpersonal skills and recovery status. Dissertation, United States International University. *Dissertation Abstracts International*, 56(08B), 4579. Johnson, M.E. & Prentice, D.G. (1990). Effects of counselor gender and drinking status on perceptions of the counselor. *Journal of Alcohol and Drug Education*, 35, 38-44. Kirk, W.G., Best, J.B., & Irwin, P. (1986). The perception of empathy in alcoholism counselors. *Journal of Studies on Alcohol*, 47, 82-84. Simmering, J.A. (1986). Effect of shared history of alcoholism on client perceptions of counselor characteristics. *Dissertation Abstracts International*, 47(1), 87-A-88-A. Toriello, P.J. & Strohmmer, D.C. (2004). Addictions counselors' credibility: The impact of interactional styles, recovery status, and nonverbal behavior. *Journal of Addictions and Offender Counseling*, 25(1), 43-57.
- ⁵⁹⁹ Berzins, J.I. & Ross, W.F. (1972). Experimental assessment of responsiveness of addict patients to the "influence" of professionals versus other addicts. *Journal of Abnormal Psychology*, 80(November), 141-148.
- ⁶⁰⁰ LoBello, S.G. (1984). Counselor credibility with alcoholics and non-alcoholics: It takes one to know one? *Journal of Alcohol and Drug Education*, 29(2), 58-66.
- ⁶⁰¹ McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, 4(1), 43-60.
- ⁶⁰² Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1987). Attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, 175, 653-660. Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1988). Differences among treatment clinic types in attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, 176, 714-718.
- ⁶⁰³ Savage, M. & Stickles, J. (1990). Adolescent and counselor preferences for recovering vs. non-recovering alcoholism counselors. *Journal of Adolescent Chemical Dependency*, 1(2), 117-138.

alcoholism would provide the most effective assistance for alcohol problems. Both graduate students preparing to become counselors and practicing counselors expressed a preference for the recovering counselor (47% to 21%); 86% of high school students preferred the recovering counselor. Another interesting finding was that recovering alcoholics in AA perceived counselors in recovery more positively than did alcoholics initially seeking recovery, suggesting the potential utility of using recovering people for post-treatment recovery support services or for clinical work with AA members who have relapsed after some period of sobriety.⁶⁰⁴ As a point of comparison, most program administrators who were surveyed in 1992 reported that recovering counselors and counselors without a history of addiction were equally effective.⁶⁰⁵

The mixed findings on this question of client-perceived credibility or preferences related to recovery status are similar to mixed findings from the general disability literature on whether persons with disabilities prefer working with counselors who share their disability. This literature, like studies of addiction recovery status, notes a preference for peer status or no finding of peer preference, but there are no studies noting that a shared disability would disqualify someone as an effective counselor.⁶⁰⁶ White and Kurtz (2006)⁶⁰⁷ have described three types of attitudes toward personal recovery—recovery-positive, recovery-neutral, and recovery-negative identities. The last of these categories embraces people who feel great shame attached to their addiction history and recovery status, reject the “disability identity,” and seek to “pass” socially by rigorously hiding their recovery status. This raises at least the theoretical possibility that internalized stigma might lead these individuals to perceive an assigned helper in recovery as less credible and less effective. Such perceptions might contribute to increased resistance and weak therapeutic alliance.

COUNSELOR RECOVERY STATUS AND THERAPEUTIC ALLIANCE

Early studies presented conflicting findings on whether counselors' recovery histories bestowed heightened capacities for therapeutic alliance with clients entering addiction treatment. Talbott and Gillen⁶⁰⁸ compared a group of recovering counselors to counselors with no addiction history and found that

⁶⁰⁴ Priester, P.E., Azen, R. Speight, S., & Vera, E.M. (2007). The impact of counselor recovery status similarity on perceptions of attractiveness with members of Alcoholics Anonymous: An exception to the repulsion hypothesis. *Rehabilitation Counseling Bulletin*, 51, 14-20.

⁶⁰⁵ Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73, 596-603.

⁶⁰⁶ Priester, P.E., Azen, R. Speight, S., & Vera, E.M. (2007). The impact of counselor recovery status similarity on perceptions of attractiveness with members of Alcoholics Anonymous: An exception to the repulsion hypothesis. *Rehabilitation Counseling Bulletin*, 51, 14-20.

⁶⁰⁷ White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

⁶⁰⁸ Talbott, J.A. & Gillen, C. (1978). Differences between nonprofessional recovering alcoholic counselors treating Bowery Alcoholics: A study of therapist variables. *Psychiatric Quarterly*, 50(4), 333-342.

recovery status predicted neither a uniform set of counselor values nor uniform clinical outcomes (as measured by engagement and retention rates). In contrast, Lawson used the Barrett-Lennard Relationship Inventory to compare the scores of recovering counselors and counselors without a history of addiction and found that prior alcoholism recovery was “a significant factor in the quality of the relationship which existed between counselors and patients...”⁶⁰⁹ Machell⁶¹⁰ conducted a study of the influence of a client’s primary counselor’s recovery status on the client’s sense of belonging within the treatment milieu, length of stay in treatment, and post-treatment relapse rates. No differences by counselor recovery status were found. A similar lack of differences in perception of empathy and therapeutic alliance has been reported in other studies.⁶¹¹

Meier, Barrowclough, and Donmall conducted a recent literature review concerning therapeutic alliance in addiction treatment.⁶¹² They concluded: “More experienced counselors were able to retain their clients in treatment for longer, and length of experience of delivering counseling appeared to be a more influential predictor than having a formal counseling qualification.”⁶¹³ This is congruent with findings from the general disabilities literature indicating that a shared status with the client engenders a working relationship with the helpee only in the presence of at least a minimum level of helping skills.⁶¹⁴

Sanders, Trinh, Sherman, and Banks⁶¹⁵ compared peer-led counseling groups with counseling groups led by addiction counselors. They found that clients with peer counselors were more likely to describe them as empathic and to identify them as the most helpful part of their treatment experience.

COUNSELOR RECOVERY STATUS AND ETHICAL DECISION-MAKING

Recovery status raises ethical issues within counseling, case management, and other service roles that are more complex than for helpers not in personal recovery—greater complexity in dual relationships, ambiguities

⁶⁰⁹ Lawson, G. (1982). Relation of counselor traits to evaluation of the counseling relationship by alcoholics. *Journal of Studies on Alcohol*, 43, 834-839, quotation from p. 836.

⁶¹⁰ Machell, D.F. (1991). Counselor substance abuse history, client fellowship, and alcoholism treatment outcome: A brief report. *Journal of Alcohol and Drug Education*, 37(1), 25-30.

⁶¹¹ Kirk, W.G., Best, J.B., & Irwin, P. (1986). The perception of empathy in alcoholism counselors. *Journal of Studies on Alcohol*, 47, 82-84.

⁶¹² Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, 100, 304-316.

⁶¹³ Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, 100, 304-316.

⁶¹⁴ Leierer, S.J., Strohmer, D.C., & Leclerc, W.A. (1996). The effect of counselor disability, attending behavior, and client problem on counseling. *Rehabilitation Counseling Bulletin*, 40, 82-90.

⁶¹⁵ Sanders, L. M., Trinh, C., Sherman, B. R., & Banks, S. M. (1998). Assessment of client satisfaction in a peer counseling substance abuse treatment program for pregnant and postpartum women. *Evaluation and Program Planning*, 21, 287-296.

related to self-disclosure, potential role conflict with other professionals, and confidentiality within service relationships and recovery community relationships.⁶¹⁶

Torriello and Benshoff⁶¹⁷ evaluated the sensitivities of addiction counselors facing ethical dilemmas. In a surprising finding, those with an associate's degree or high school diploma (recovery status of the sample was not identified, but lower education continues to be a proxy for counselor recovery status in many treatment programs) exhibited greater ethical sensitivity than those with a graduate degree. Sias, Lambie, and Foster⁶¹⁸ studied the influence of recovery status on moral reasoning in addiction counselors. They found no differences between the moral reasoning abilities of recovering counselors and those of counselors without addiction histories. McCollum⁶¹⁹ compared recovering addiction counselors and addiction counselors without addiction histories regarding their beliefs about dual relationships. Counselors not in recovery found dual/multiple relationships more ethically problematic than did recovering counselors. This difference might be related to the fact that recovering counselors more frequently encounter clients in recovery support group meetings and have learned how to clearly define and separate these roles. This explanation draws some support from a study by Bachrach⁶²⁰ that compared peer helpers within a union-based peer assistance program within the airline industry. The study found that peer helpers in recovery used more assertive relationship boundary management tactics than did peer helpers who were not in recovery.

The P-BRSS literature suggests three levels of intimacy in the helping relationship: 1) a zone of enmeshment marked by extreme directiveness, over-involvement, and possessiveness; 2) a zone of disengagement marked by coldness, passivity, and physical and emotional detachment; and 3) a zone of appropriateness and effectiveness marked by firmness, continuity of contact, and support that remains within the educational and experiential capabilities of the P-

⁶¹⁶ Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumers-providers: Barriers and alternative solutions. *Community Mental Health Journal*, 37(3), 199-213. White, W. & Popovits, R. (2001). *Critical incidents: Ethical issues in the prevention and treatment of addiction*. Bloomington, IL: Chestnut Health Systems. White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits, R. & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

⁶¹⁷ Torriello, P.J. & Benshoff, J.J. (2003). Substance abuse counselors and ethical dilemmas: The influence of recovery and education level. *Journal of Addictions and Offender Counseling*, 23(2), 83-98.

⁶¹⁸ Sias, S.M, Lambie, G.W., & Foster, V.A. (2006). Conceptual and moral development of substance abuse counselors: Implications for training. *Journal of Addictions and Offender Counseling*, 26(2), 99-110.

⁶¹⁹ McCollum, V. (2006). Beliefs of board certified substance abuse counselors regarding multiple relationships. *Journal of Mental Health Counseling*, 28, 84-94. Retrieved August 25, 2008 from <http://www.thefreelibrary.com/Beliefs+of+board+certified+substance+abuse+counselors+regarding...-a0141212922>.

⁶²⁰ Bacharach, S. B. (2000). Boundary management tactics and logics of action: The case of peer-support providers. *Administrative Science Quarterly*, 45, 704-736.

BRSS specialist.⁶²¹ The boundaries demarcating these zones are poorly defined, but there are ethical guidelines emerging to guide the delivery of P-BRSS that are based on recovery community values and collective experience as opposed to guidelines that simply mimic ethical standards for addiction counselors, psychologists, and social workers.⁶²²

Training of P-BRSS specialists emphasizes the importance of practicing within the boundaries of one's education, training, and experience, but some research has suggested that service providers at all levels of training consistently overestimate their skills.⁶²³ The ethical mantra to practice within the boundaries of one's education, training, and experience has meaning only if professional and peer helpers accurately perceive their limitations and use supervisory structures to validate those perceptions.

COUNSELOR RECOVERY STATUS AND CLIENT SATISFACTION WITH SERVICES

Mavis and Stöffelmayr⁶²⁴ conducted a study of factors related to client satisfaction with addiction treatment. The clients in their study who were treated by recovering staff reported higher ratings of satisfaction with treatment than those treated by staff not in recovery. Ball, Graff, and Sheehan⁶²⁵ conducted a study of heroin addicts' views of methadone maintenance treatment. Although ex-addicts filled only four of 44 staff positions, 60% of patients identified the ex-addict counselors as the most helpful part of their treatment experience.

COUNSELOR RECOVERY STATUS AND CLIENT RECOVERY OUTCOMES

In comparing the clinical outcomes of addiction counselors, three preliminary points are noteworthy: 1) there are significant differences in outcomes across counselors, 2) counselor assignment accounts for greater degrees of variance in outcome than assignment to different treatment, and 3)

⁶²¹ Manohar, V. (1973). Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, 34, 869-877. White, W. & Popovits, R. (2001). *Critical incidents: Ethical issues in the prevention and treatment of addiction*. Bloomington, IL: Chestnut Health Systems.

⁶²² Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumers-providers: Barriers and alternative solutions. *Community Mental Health Journal*, 37(3), 199-213. White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits, R. & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

⁶²³ Walters, S.T., Matson, S.A., Baer, J.S., & Ziedonis, D.M. (2005). Effectiveness of workshop training for psychosocial addiction treatments: A systematic review. *Journal of Substance Abuse Treatment*, 29, 283-293.

⁶²⁴ Mavis, B.E. & Stoeffelmayr, B.E. (1994). Program factors influencing client satisfaction in alcohol treatment. *Journal of Substance Abuse*, 6, 345-354.

⁶²⁵ Ball, J.C., Graff, H., & Sheehan, J.J., Jr. (1974). The heroin addict's view of methadone maintenance. *British Journal of the Addictions*, 69(1), 89-95.

differences in outcomes across counselors may be greater in the addictions field than in other areas of counseling.⁶²⁶

The earliest professional reports on client outcomes by helper recovery status were primarily observational.⁶²⁷ Slaughter and Torno⁶²⁸ described a peer-based counselor program in which senior patients were assigned to mentor incoming clients, lead groups, and even manage a treatment unit. Their reported outcomes included higher patient retention rates and greater insight of patients into their problems. Brown and Thompson⁶²⁹ compared treatment outcomes for clients served by recovering counselors to outcomes for those served by counselors without a history of addiction. They concluded that recovery status did not enhance or detract from clinical outcomes as measured by rates of post-treatment drug use, employment, or arrest. A similar lack of recovery outcome differences by counselor recovery status was reported in studies by Valle,⁶³⁰ LoSciuto, Aiken, and Ausetts;⁶³¹ Connet;⁶³² Longwell, Miller, and Nichols;⁶³³ Moos, Finney, and Chan;⁶³⁴ Machell;⁶³⁵ and McLellan, Woody, Luborsky, and Goehl.⁶³⁶

What appear to be the most critical influences on recovery outcomes are not a counselor's recovery status or even formal education, but particular traits and the quality of addiction-specific counselor training and experience. These factors differ across counselors and are not predictable by recovery status of the

⁶²⁶ Najavits, L. M., Crits-Christoph, P., & Dierberger, A. (2000). Clinicians' impact on the quality of substance use disorder treatment. *Substance Use and Misuse*, 35, 12-14. Najavits, L. M. & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction*, 89, 679-688.

⁶²⁷ Anderson, D. (1944). The place of the lay therapist in the treatment of alcoholics. *Quarterly Journal of Studies on Alcohol*, 5, 257-266.

⁶²⁸ Slaughter, L.D. & Torno, K. (1968). Hospitalized alcoholic patients. IV. The role of patient-counselors. *Hospital and Community Psychiatry*, 19, 209.

⁶²⁹ Brown, B. S. & Thompson, R. F. (1975). The effectiveness of formerly addicted and nonaddicted counselors on client functioning. *Drug Forum*, 5(2), 123-129.

⁶³⁰ Valle, S.K. (1977). Relative effectiveness of degreed and non-degreed alcoholism counselors. *Maryland State Medical Journal*, 26(11), 12-14.

⁶³¹ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

⁶³² Connett, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, 15(4), 585-589.

⁶³³ Longwell, B., Miller, J., & Nichols, A.W. (1978). Counselor effectiveness in a methadone maintenance program. *The International Journal of the Addictions*, 13(2), 307-315.

⁶³⁴ Moos, R., Finney, J., & Chan, D. (1981). The process of recovery from alcoholism: 1. Comparing alcoholic patients and matched community controls. *Journal of Studies on Alcohol*, 42, 383-402.

⁶³⁵ Machell, D.F. (1991). Counselor substance abuse history, client fellowship, and alcoholism treatment outcome: A brief report. *Journal of Alcohol and Drug Education*, 37(1), 25-30.

⁶³⁶ McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation: An examination of treatment success among four counselors. *Journal of Nervous and Mental Disorders*, 176(7), 423-430.

counselor.⁶³⁷ Valle⁶³⁸ conducted a study of the differences in client recovery rates assigned to eight recovering counselors. There were significant differences in client recovery outcomes across the counselors, with clients of recovering counselors with the highest levels of interpersonal functioning achieving the best post-treatment recovery rates (as measured by rates of continuous sobriety and number and duration of relapse episodes).

Seven studies identified in this review found at least slight differences in clinical outcomes by the recovery status of the counselors. All but one of these studies were conducted in the 1970s and 1980s. Argeriou and Maohar⁶³⁹ found general equivalency of outcomes but found that younger clients had better recovery rates when assigned to recovering alcoholic counselors. Ottomanelli⁶⁴⁰ compared the pre-treatment and post-treatment MMPI scales of clients assigned to professional and paraprofessional addiction counselors. There were no changes in pre/post MMPI scales for the clients of recovering counselors, but two of the post-treatment MMPI scales (the D and Sc scales) were lower for clients who had professional counselors—a finding limited by the small number of counselors in the study. LaRosa and colleagues randomly assigned clients in methadone treatment to group therapy conducted by master's-level therapists or ex-addict counselors. At one year follow-up, the professional therapists had retained more clients in treatment than the ex-addict counselors (68% versus 40%) and achieved higher satisfaction ratings.⁶⁴¹ Brown and colleagues⁶⁴² found that opiate clients had higher treatment retention rates when they were assigned professional rather than ex-addict counselors. Aiken and colleagues⁶⁴³ found general equivalency between recovery rates of clients of recovering paraprofessionals, paraprofessionals without addiction histories, and professionals without addiction histories, but noted that clients counseled by professionals were more likely to pursue educational activities than were clients in the other two groups. King⁶⁴⁴ found that alcoholics treated by recovering

⁶³⁷ LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

⁶³⁸ Valle, S. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol*, 42, 783-790.

⁶³⁹ Argeriou, M. & Monohar, V. (1978). Relative effectiveness of non-alcoholics and recovered alcoholics as counselors. *Journal of Studies on Alcohol*, 39, 793-799.

⁶⁴⁰ Ottomanelli, G.A. (1978). Patient improvement, measured by the MMPI and Pyp, related to paraprofessional and professional counselor assignment. *International Journal of the Addictions*, 13, 503-507.

⁶⁴¹ LaRosa, J.C., Lipsius, S.H. & LaRosa, J.H. (1974). Experiences with a combination of group therapy and methadone maintenance in the treatment of heroin addiction, *International Journal of the Addictions*, 9, 605-617

⁶⁴² Brown, B.S., Gfroerer, J., Thompson, P., & Berdine, A. (1985). Setting and counselor type as related to program retention. *International Journal of the Addictions*, 20(5), 723-36.

⁶⁴³ Aiken, L., LoSciuto, L., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: The progress of clients in treatment. *International Journal of Addictions*, 19(4), 383-401.

⁶⁴⁴ King, B.E. (1997). A comparison of sobriety success rates between alcoholic clients with recovering alcohol counselors vs. non-alcoholic counselors and metaphoric vs. non-

alcoholic counselors had higher post-treatment sobriety rates than did clients with counselors without recovery history. Snowden and Cotler (1974)⁶⁴⁵ conducted an early study of the relationship between the personality characteristics of 25 paraprofessional ex-addict counselors working within a methadone program (as measured by the MMPI) and client outcomes (as measured by medication compliance, rates of attendance at counseling sessions, and negative urine tests). Counselors with personality traits usually regarded as “non-adjustive or even pathological” (e.g., concern with bodily functions, pervasive suspicion, hypersensitivity, emotional excitability as evidenced by enthusiasm or irritation) had higher client success rates. They concluded:

*Perhaps most counselors, as newly reformed addicts of virtually equivalent duration, experience comparable amounts of personal distress. However, some are non-defensive or even overly prepared to acknowledge and explore these difficulties, while others deny the existence of such problems. Hence, the former group would probably be characterized by greater self-exploration, honesty, and openness to experience. These conditions have been related to therapeutic success.*⁶⁴⁶

This review confirms what folk wisdom in the field has long conveyed:

*Addiction recovery can be a valuable asset to the helping process only when other conditions are met. Addiction recovery is by no means a necessary and sufficient criterion for counseling success.*⁶⁴⁷

This folk wisdom was again empirically confirmed in a study of therapist effects on clinical outcomes in Project MATCH (1998b),⁶⁴⁸ which found significant therapist effects on outcomes, but these effects were unrelated to recovery status.

Client outcomes were unrelated to therapists’ self-reports of being “alcoholic,” having had alcohol problems, or being “in recovery.” This is consistent with a large literature showing that a therapist’s personal

metaphoric counseling. Dissertation, Texas A&M University-Kingsville. *Dissertation Abstracts International*, 59(05B), 2156.

⁶⁴⁵ Snowden, L. & Cotler, S. (1974). The effectiveness of paraprofessional ex-addict counselors in a methadone treatment program. *Psychotherapy: Theory, Research & Practice*, 11(4), 331-338.

⁶⁴⁶ Snowden, L. & Cotler, S. (1974). The effectiveness of paraprofessional ex-addict counselors in a methadone treatment program. *Psychotherapy: Theory, Research & Practice*, 11(4), 331-338.

⁶⁴⁷ Wolf, S. (1983). Criteria for effectiveness: Recovered professionals as counselors. *Focus on Alcohol and Drug Issues*, 6(3), 22, 28.

⁶⁴⁸ Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, 8, 455-474.

*history of alcoholism and recovery neither benefits nor hinders his or her effectiveness in the treatment of substance abuse.*⁶⁴⁹

Stöffelmayr and colleagues raised a provocative question related to the findings we have just reviewed:

*...if professionals and paraprofessionals are equally effective [in addiction counseling] and cannot be differentiated in their approach to clients, why all these efforts to train paraprofessionals in the image of the professional counselor?*⁶⁵⁰

The above findings and conclusions are based on experience with recovering people working in specialty sector addiction treatment programs serving adults. They may or may not apply to the effectiveness of recovering people working as addiction counselors in adolescent treatment programs. Only one early (1978) study was located that specifically addressed this question. DeAngelis and Ross reported on a study conducted at Pride House, a therapeutic community for adolescents that was transitioning from a predominately ex-addict staff to a professional staff. Concerning the comparison of performance of ex-addict professionals and non-addict professionals, DeAngelis and Ross noted the following findings.

- Ex-addict professionals had longer tenures of employment and lower turnover than did non-addict professionals.
- Eight percent of non-addict professionals and 46% of ex-addict professionals who left Pride House were discharged for unethical conduct.
- There were no significant differences in client retention rates between the ex-addict and non-addict professionals.
- Non-addict professionals averaged 11 more client contacts per month than did ex-addict professionals.⁶⁵¹

There were no reports of post-treatment recovery outcome based on client assignment to ex-addict or non-addict professional. The extent to which finding in the DeAngelis and Ross study are unique to this program, or to that era of addiction counseling, is unknown due to the lack of other studies.

⁶⁴⁹ McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an “active ingredient” in substance abuse rehabilitation: An examination of treatment success among four counselors. *Journal of Nervous and Mental Disorders*, 176(7), 423-430. Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, 8, 455-474.

⁶⁵⁰ Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors’ approach to treatment. *Journal of Psychoactive Drugs*, 31(2), 121-127, quote from page 127.

⁶⁵¹ De Angelis, G.G. & Ross, E.A. (1978). A comparison of nonaddict and ex-addict professionals in an adolescent treatment program. *Drug and Alcohol Dependence*, 3(5), 319-329.

RECOVERY STATUS AND GENERAL JOB PERFORMANCE FACTORS

Blum and Roman⁶⁵² conducted a comparison of recovering occupational alcoholism consultants (OPCs) and OPCs without a history of addiction. They found substantial similarity between the two groups, with no differences found related to effectiveness of job performance. Recovering OPCs did report higher levels of job commitment and job satisfaction. Aiken and LoSciuto⁶⁵³ conducted a study to evaluate counselor knowledge of drug use by their clients. Recovering staff were more accurate in identifying drug use of their clients than were non-addict counselors.

VULNERABILITY TO RELAPSE AMONG COUNSELORS IN RECOVERY

In the professional literature on addiction counseling there are innumerable references to the risk of relapse for recovering counselors, but few studies have measured the actual prevalence of counselor relapse. Rhodes and White⁶⁵⁴ reported on 274 ex-addicts hired to fill multiple roles in the Illinois Drug Abuse Program between 1968 and 1973. They reported that 48% of this group had “failed” and that failure most frequently involved a return to drug use (six subsequent drug-related deaths were reported in this sample). It should be noted that this high failure and relapse rate occurred at a time when the emerging drug abuse treatment field knew little about the screening, hiring, orientation, training, and supervision of ex-addicts in helping roles.

Ten years later Kinney⁶⁵⁵ conducted a 10-year follow-up of recovered alcoholics completing an alcoholism counselor training program. In that study, 37.5% of the graduates reported having experienced a relapse during the 10-year period. This is consistent with a survey of treatment programs in 1992, in which 39% of administrators reported that their agencies had experienced the relapse of an employee in recovery.⁶⁵⁶ The same year, Kahn and Fau conducted a similar study of 145 recovering alcoholics trained to become alcoholism counselors (in successive classes over a 10-year period).⁶⁵⁷ Only 4.8% of those training graduates reported having relapsed since completion of the training.

⁶⁵² Blum, T. & Roman, P. (1985). The social transformation of alcoholism intervention:

Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors. *Journal of Health and Social Behavior*, 26(4), 365-378.

⁶⁵³ Aiken, L.S. & LoSciuto, L.A. (1985). Ex-addict versus non-addict counselors' knowledge of clients' drug use. *International Journal of the Addictions*, 20, 417-433.

⁶⁵⁴ Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman.

⁶⁵⁵ Kinney, J. (1983). Relapse among alcoholics who are alcoholism counselors. *Journal of Studies on Alcohol*, 44(4), 744-748.

⁶⁵⁶ Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, 73, 596-603.

⁶⁵⁷ Kahn, M.W. & Fua, C. (1992). Counselor training as a treatment for alcoholism: The helper therapy principle in action. *The International Journal of Social Psychiatry* 38, 208-214.

This replicated findings from an earlier study of Kahn and Fau⁶⁵⁸ in which only four of 25 alcoholics training as alcoholism counselors experienced a brief relapse after the training, but all had at least a year of sobriety at the follow-up evaluation.

The differences among these studies reflect, in part, a longer period of study in which the Kinney subjects might have relapsed and the years of history reflected in the Anderson and Wiemer study of treatment administrators, compared to the Kahn and Fau sample that included recent graduates.

Seen as a whole, these studies suggest that the risk of relapse among addiction counselors in recovery progressively declined between the 1960s and 1990s, probably as a function of increased role clarity as well as improved screening, selection, orientation, training, and supervision. Substance-related impairment continues to be a concern for addiction counselors. In a national survey of addiction counselor certification boards, 40 boards representing more than 32,900 certified addiction counselors reported a total of 373 ethical complaints during the years 1991 and 1992. Forty-six (12.4%) of those complaints were related either to impairment from substance use or to psychiatric impairment.⁶⁵⁹ The portion of these cases that resulted in relapse of a recovering counselor (as opposed to a new substance use disorder of a counselor not previously in recovery) or to the development of mental health problems among counselors is unknown.

INFLUENCE OF RECOVERY STATUS ON SUPERVISORY RELATIONSHIPS

There are only two studies that focus on the effects of the recovery status of the supervisor on supervisory relationships with addiction counselors of varied recovery status. Culbreth and Borders⁶⁶⁰ found that a positive and supportive attitude was more important than recovery status in influencing the supervisory relationship. There were no differences in satisfaction with supervision based on recovery status of the supervisee and supervisor, but both recovering counselors and counselors without histories of addiction noted the potential for mismatches in which the supervisor discounted the professional or personal recovery experience of the counselor based on whether or not the supervisor had a history of addiction recovery.

In a follow-up study examining the content of supervision based on recovery status of the supervisor and supervisee, Culbreth⁶⁶¹ found that recovery status of the counselor did influence the topical focus of supervision, with

⁶⁵⁸ Kahn M.W. & Fua, C. (1985). Counselor training as a therapy for alcohol abuse among aboriginal people. *American Journal of Community Psychology*, 3(5), 613-616.

⁶⁵⁹ St. Germaine, J. (1997). Ethical practices of certified addiction counselors: A national survey of state certification boards. *Alcoholism Treatment Quarterly*, 15, 63-72.

⁶⁶⁰ Culbreth, J.R. & Borders, L.D. (1998). Perceptions of the supervisory relationships: A preliminary qualitative study of recovering and nonrecovering substance abuse counselors. *Journal of Substance Abuse Treatment*, 15(4), 345-352.

⁶⁶¹ Culbreth, J. R. (1999). Clinical supervision of substance abuse counselors: Current and preferred practices. *Journal of Addictions and Offender Counseling*, 20, 15-25.

recovering counselors preferring more supervisory time focused on client typologies, ethical/legal issues, and personal/professional support.

EVALUATION OF TREATMENT MODELS STAFFED BY RECOVERING PEOPLE

Scientific studies have been conducted of four treatment/recovery models that rely almost exclusively on recovering people as helping agents: social model alcoholism programs, early ex-addict-directed therapeutic communities, early Minnesota Model chemical dependency programs, and the Twelve Step Facilitation arm of Project MATCH.

Social models of alcoholism recovery grew out of experiments with “AA farms” and “AA retreats” in the 1940s and 1950s.⁶⁶² Social model programs (SMPs) provide support for people voluntarily seeking recovery from alcoholism in a home-like, democratically governed residential environment that emphasizes the principles and practices of Alcoholics Anonymous. SMPs help people construct a sobriety-based social network that includes AA members and program alumni. SMPs are staffed by people whose authority is based on personal recovery experience rather than professional education and training. The primary catalyst for recovery is the relationship between the person and a community of recovering people, rather than the relationship between a client and a therapist. Learning about recovery occurs through modeling and discussion rather than through didactic instruction, and relationships between SMP staff and participants/residents (not clients or patients) are egalitarian rather than hierarchical. Responsibility for initiating and sustaining sobriety is the responsibility of each participant who draws support from his or her peers in recovery. SMPs rely on client-centered recovery planning rather than on staff-directed treatment planning.⁶⁶³

A review of early evaluations of SMPs reported sustained abstinence in 33% of participants and reduced substance use in 21% of participants. These evaluations also reported enhanced employment and family incomes and reductions in criminal activity comparable to those achieved in clinical models of treatment, but at dramatically reduced costs.⁶⁶⁴ A recent and methodologically

⁶⁶² See White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁶⁶³ Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, 15(1), 37-42. Borkman, T., Kaskutas, L.A., & Barrows, D.C. (1996). *The social model program: A literature review and history*. Rockville, MD: Center for Substance Abuse Treatment. Borkman, T. J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, 15(1), 7-17. Wright, A. (1991). What is social model? In S. Shaw & T. Borkman (Eds.), *Social model alcohol recovery: An environmental approach* (pp. 7-10). Burbank, CA: Bridge Focus, Inc.

⁶⁶⁴ Borkman, T. J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, 15(1), 7-17.

rigorous study⁶⁶⁵ compared recovery outcomes in social and non-social model programs. At one-year follow-up, more clients treated in social model programs reported an absence of alcohol problems than did clients treated in clinical programs (57% to 49%), and a greater percentage also reported having no drug problems (59% to 51%). Other outcomes, such as reported medical, psychiatric, and family problems, were similar across program type. The reported effects of the social model programs may be mediated by levels of AA and NA participation that were higher at follow-up than the levels of such participation among clients treated in clinical programs.

Evaluations of fidelity to the core elements of the SMP reveal considerable fidelity erosion over time. Three factors contribute to the erosion of this model: 1) funding policies that do not reimburse key elements of the social model, 2) regulatory requirements that force a more institutional and less home-like environment, and 3) the professionalization of the SMP peer support relationship.⁶⁶⁶

The Minnesota Model (MM) of chemical dependency treatment, like social model programs, began as a peer-based approach to alcoholism recovery.⁶⁶⁷ It then evolved through several stages that included delivery of services via a multidisciplinary team and the subsequent professionalization of the role of the alcoholism counselor within that team.⁶⁶⁸ Today's chemical dependency counselor within the MM is less likely to be in recovery and, if in recovery, is more likely to have a college or post-graduate degree in a counseling-related field as well. Today, the 12-Step philosophy that was once the centerpiece of the MM is more likely to be presented alongside multiple philosophies and approaches. As a result, clients treated within these programs today are less likely to receive the intense exposure to recovering alumni, AA volunteers, and AA meetings in the community than was the norm decades ago. In light of all these changes, the earliest evaluations of the MM (those prior to 1980), although methodologically weaker than later studies, may give a more accurate evaluation of the influence of peer-based recovery support.

Rossi, Stach, and Bradley⁶⁶⁹ conducted the first detailed MM follow-up study of patients admitted to Willmar State Hospital (mean follow-up period of over 21 months) and reported that 24% of patients had been abstinent for six months or more prior to follow-up, and 14% had been abstinent since discharge. Laundergan⁶⁷⁰ evaluated clients discharged from Hazelden between 1973 and 1975, and reported that 50% were abstinent at follow-up (57.1% adjusted for

⁶⁶⁵ Kaskutas, L. A., Ammon, L. N., & Weisner, C. (2003-4). A naturalistic analysis comparing outcomes of substance abuse treatment programs with different philosophies: Social and clinical model perspectives. *International Journal of Self Help and Self Care*, 2, 111-133.

⁶⁶⁶ Kaskutas, L. A., Keller, J. W., & Witbrodt, J. (1999). Measuring social model in California: How much has changed? *Contemporary Drug Problems*, 26, 607-631.

⁶⁶⁷ This refers to the early recovery models at Pioneer House and Hazelden in the late 1940s.

⁶⁶⁸ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁶⁶⁹ Rossi, J., Stach, A., & Bradley, N. (1963). Effects of treatment of male alcoholics in a mental hospital: A follow-up study. *Quarterly Journal of Studies on Alcohol*, 24, 91-108.

⁶⁷⁰ Laundergan, J. (1982). *Easy does it: Alcoholism treatment outcomes, Hazelden and the Minnesota Model*. Center City, Minnesota: Hazelden Foundation.

non-response, deaths, and treatment re-entry) and 17.6% were improved—defined as drinking at the time of follow-up but at levels lower than pre-treatment levels. Cook⁶⁷¹ reviewed outcome studies for MM programs from this period and concluded: “Despite exaggerated claims of success, it [the Minnesota Model] appears to have a genuinely impressive ‘track record’ with as many as two-thirds of its patients achieving a ‘good’ outcome at 1 year after discharge.”⁶⁷²

The therapeutic community (TC), although considerably different from social model and Minnesota Model programs,⁶⁷³ also underwent changes that decreased its peer orientation. These changes include the professionalization of staff and the subsequent shift in relational status from “brothers” and “sisters” living and learning together within the TC “family” to “clients” being “treated” by professional staff. TCs have also shifted from an exclusive reliance on peer-support from inside the TC to the integration of involvement in 12-Step groups in the local community. In the TC world, “peer” now extends to people beyond the TC community.

De Leon⁶⁷⁴ reviewed the early TC effectiveness data and reported consistent positive outcomes, including post-treatment decreases in drug use and criminality and increases in employment and other indices of social adjustment. Two limitations to these findings are critical. First, positive outcomes were directly related to dose of treatment, with 120-180 days being the minimum dose for positive outcomes. Second, only 10-20% of people admitted to TCs successfully completed all phases of treatment. For example, early studies of Phoenix House revealed very high dropout rates (between 71-78%), but there were also high rates of sustained abstinence for those completing the TC program (94% at 12 months following completion).⁶⁷⁵ More than 60% of early TC graduates assumed staff positions within the TC in which they had graduated

⁶⁷¹ Cook, C. (1988a). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part I. Philosophy and the programme. *British Journal of Addiction*, 83, 625-34. Cook, C. (1988b). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part II. Evidence and conclusions. *British Journal of Addiction*, 83, 735-748.

⁶⁷² In a later one-year follow-up study of more than 1,000 Hazelden graduates, 53% reported continuous abstinence since discharge, and 35% had reduced their alcohol and drug use. Stinchfield, R. & Owen, P. (1998). Hazelden’s model of treatment and its outcome. *Addictive Behaviors*, 23(5), 669-683. Cook, C. (1988b). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part II. Evidence and conclusions. *British Journal of Addiction*, 83, 735-748.

⁶⁷³ Borkman, T., Kaskutas, L.A., & Owen, P. (2007). Contrasting and converging philosophies of three models of alcohol/other drugs treatment: Minnesota model, social model and addiction therapeutic communities. *Alcoholism Treatment Quarterly*, 25(3), 21-38.

⁶⁷⁴ De Leon G. (1984). *The therapeutic community: Study of effectiveness* (NIDA Treatment Research Monograph Series, DHHS Publication (ADM) 85-1286). Rockville, MD: National Institute on Drug Abuse.

⁶⁷⁵ De Leon, G., Holland, S., & Rosenthal, M.S. (1972). Therapeutic community for drug addicts, long-term measurement of emotional changes. *Psychological Reports*, 29, 595-600. Nash, G. Waldorf, D., Foster, K., & Kyllingstad, A. (1974). The Phoenix House program: The results of a two year follow-up. In G. De Leon (Ed.), *Phoenix House: Studies in a therapeutic community (1968-1973)*. New York: MSS Information.

or in a similar program⁶⁷⁶—a finding that triggered concern that ex-addict staff may not be well equipped to guide clients' community reintegration.⁶⁷⁷

Social model programs, Minnesota Model programs, and therapeutic communities all became less peer oriented over time, due to trends in the broader field of addiction treatment. These trends included professionalization, regulation (and its accompanying paperwork burdens), commercialization, the shift in preference from inpatient/residential to outpatient treatment modalities, and the shortened treatment duration that has been a result of managed behavioral health care.⁶⁷⁸ Those changes set the stage for the re-emergence of more purely peer-based recovery models such as recovery homes, the growth of recovery community centers, the role of the recovery coach, and other peer-support specialty roles.

Project MATCH was a multi-site (nine treatment units), randomized trial to evaluate the benefits of matching clients who meet diagnostic criteria for alcohol abuse or alcohol dependence to three different specialized treatments. The three treatments included Cognitive Behavioral Coping Skills (CBT), Motivational Enhancement Therapy (MET), and Twelve-Step Facilitation (TSF). All were delivered over a 12-week period either as outpatient treatment or as an aftercare intervention following completion of inpatient or intensive day-hospital treatment.

Key findings of the Project MATCH study included sustained reductions in drinking among clients in all three treatments and the lack of clear superiority of one treatment over another. Findings related to matching variables were few: clients low in psychiatric severity who participated in TSF achieved better abstinence outcomes at one-year follow-up than did those who participated in CBT.⁶⁷⁹ The superiority of TSF over CBT on abstinence outcomes continued at year three follow-up.⁶⁸⁰

The relevance of this finding to our current discussion is that TSF focused on promoting acceptance of alcoholism as a disease and on fostering a commitment to participate in Alcoholics Anonymous and AA "step work," and was delivered primarily by therapists in 12-Step recovery from alcoholism who were also masters-trained and/or state-certified alcoholism counselors.⁶⁸¹ The superior outcomes of the TSF intervention appear to be related to increased

⁶⁷⁶ Scott, D. & Goldberg, H.L. (1973). The phenomenon of self-perpetuation in Synanon-type drug treatment programs. *Hospital and Community Psychiatry*, 24, 231-233.

⁶⁷⁷ Brown, B.S. (1979). *Addicts and aftercare: Community integration of the former drug user*. Beverly Hills: SAGE Publications.

⁶⁷⁸ Borkman, T., Kaskutas, L.A., & Owen, P. (2007). Contrasting and converging philosophies of three models of alcohol/other drugs treatment: Minnesota model, social model and addiction therapeutic communities. *Alcoholism Treatment Quarterly*, 25(3), 21-38.

⁶⁷⁹ Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, 58, 7-29.

⁶⁸⁰ Project MATCH Research Group. (1998a). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research*, 22(6), 1300-1311.

⁶⁸¹ Carroll, K. M., Kadden, R. M., Donovan, D. M., Zweben, A., & Rounsaville, B. J. (1994). Implementing treatment and protecting the validity of the independent variable in treatment matching studies. *Journal of Studies on Alcohol, Supplement 12*, 149-155.

levels of post-treatment AA participation. Reports of client satisfaction and post-treatment drinking outcomes were not related to counselor recovery status.⁶⁸²

EVALUATION OF RECOVERY VOLUNTEER PROGRAMS LINKED TO ADDICTION TREATMENT OR MEDICAL TREATMENT

Volunteer programs were very popular within addiction treatment in the mid-1970s, but a review of the literature on volunteer programs conducted in 1980 found no studies evaluating the effects of volunteer support on client recovery outcomes⁶⁸³ The broader evaluation of such programs revealed consistently positive responses regarding the role of volunteers in general and the role of indigenous volunteers in recovery.⁶⁸⁴ Typical of these early evaluations was that conducted by Manohar,⁶⁸⁵ which found that a volunteer program within the Alcoholism Division of Boston City Hospital eliminated the waiting list for services, increased patient retention, and enhanced continuity of care following discharge. Volunteers in recovery with more than one year of sobriety at this site were more likely to establish relationships with patients characterized by warmth and non-possessiveness than were those with less sobriety or who were not in recovery.

There are more recent evaluations of volunteer programs within the addiction services arena. Blondell and colleagues⁶⁸⁶ compared patients hospitalized for alcohol-related trauma who were randomly assigned to care as usual, a brief 5-to-15-minute physician intervention, or a 30-to-60-minute meeting with a recovering alcoholic (AA) volunteer. Those in the peer intervention had superior outcomes at 6-month follow-up (64% abstinence rate compared to 36% and 51% for the other interventions, and a 49% rate of treatment initiation or recovery support group involvement following discharge compared to 9% and 15% for the other two interventions). The investigators concluded that, in addition to their effectiveness, visits by AA volunteers to hospitalized patients were “simple, practical, involve no costs, and pose little patient risks.”⁶⁸⁷

⁶⁸² Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, 8, 455-474.

⁶⁸³ Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

⁶⁸⁴ Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

⁶⁸⁵ Manohar, V. (1973). Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, 34, 869-877.

⁶⁸⁶ Blondell, R.D. Looney, S.W., Northington, A.P., Lasch, M.E., Rhodes, S.B., & McDaniels, R.L. (2001). Can recovering alcoholics help hospitalized patients with alcohol problems? *Journal of Family Practice*, 50(5), 447.

⁶⁸⁷ Blondell, R.D. Looney, S.W., Northington, A.P., Lasch, M.E., Rhodes, S.B., & McDaniels, R.L. (2001). Can recovering alcoholics help hospitalized patients with alcohol problems? *Journal of Family Practice*, 50(5), 447.

Fagan⁶⁸⁸ and Fagan and Mauss⁶⁸⁹ evaluated a rehabilitation program for Skid Row alcoholics that achieved a 50% abstinence rate at follow-up from treatment. The program included teams of volunteers that “sponsored” each client’s social re-entry. The volunteers were recruited primarily from local churches, but the study did not report the recovery representation within the volunteer teams. The duties and responsibilities of the volunteer “sponsors” are listed here because of their similarity to the emerging recovery coach role: “Assist a recovering skid-row alcoholic...in relocating, bettering his or her employment, housing, and social status through moral support, acceptance, advice, shared experiences, advocacy, and reflection on problems, solutions, and personal strengths.”⁶⁹⁰

There is also a larger body of research on the effects of volunteering on the volunteer. Such studies report enhancements in physical health, confidence, self-worth, and life satisfaction, as well as reduced depression and anxiety, as predictable outcomes of volunteer activity.⁶⁹¹ There are no specific studies of the effects of volunteer activities outside of sponsorship roles on the health of people in recovery. Studies of sponsorship⁶⁹² would suggest that broader service activities might well enhance recovery outcomes, and studies of recovery volunteer programs have reported exceptionally high recovery stability rates of volunteers.⁶⁹³

Although no formal evaluations of the characteristics essential for effective volunteer recovery support work have been conducted, Manohar describes such characteristics as: “(1) *at least a high school education*; (2) *interest and experience in community service*; (3) *an authoritative rather than authoritarian approach*; (4) *a high degree of personal arousal [energy]*; (5) *ability to see alcoholism as a legitimate human experience*; (6) *acceptance of responsibility for helping others*; (7) *resilient, empathetic, self-confident and sensitive personalities*; (8) *to be able to say ‘I don’t know’ with relative ease*; and (9) *to be able to react positively to the job, and to peers, supervisors and administrators*.”⁶⁹⁴

⁶⁸⁸ Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, 16(3), 321-337.

⁶⁸⁹ Fagan, R. & Mauss, A. (1986). Social margin and social reentry: An evaluation of a rehabilitation program for skid row alcoholics. *Journal of Studies on Alcohol*, 47, 413-425.

⁶⁹⁰ Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, 16(3), 321-337, quote from page 323.

⁶⁹¹ Thoits, P. A. & Hewitt, L. N. (2001). Volunteer work and well being. *Journal of Health and Social Behavior*, 42, 115-131.

⁶⁹² Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-Step treatment of injection drug users. *Drug and Alcohol Dependence*, 65, 291-301.

Cross, G.M., Morgan, C.W., Mooney, A.J., Martin, C.A., & Rafter, J.A. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism: Clinical and Experimental Research*, 14, 169-173. Zemore, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, 100(4), 447-450.

⁶⁹³ Klein, R.F., Foucek, S.M., & Hunter, S.D. (1991). Recovering alcoholics as patient instructors in medical education. *Substance Abuse*, 12(2), 82-89.

⁶⁹⁴ Manohar, V. (1973). Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, 34, 869-877, quotation from page 871.

Collins, Barth, and Zrimec⁶⁹⁵ conducted a positive evaluation of the effects of the use of recovering alcoholic volunteers within the alcoholism program at Cleveland Metropolitan General Hospital. In this program, more than 70 local AA volunteers from 14 AA groups operated a friendship room close to the emergency room of the hospital. The volunteers provided lay counseling, escort to AA meetings, guidance in obtaining sponsors, and post-discharge follow-up.⁶⁹⁶ Collins and colleagues did note occasional problems arising within the volunteer program.

*Among the problems we have encountered are volunteers undermining or attacking the professional treatment program, volunteers becoming angry or impatient with resistant patients, volunteers allowing outsiders...to hang around the Friendship Room as if it were a drop-in center, volunteers demanding treatment for inappropriate candidates, or (rarely) volunteers relapsing to drinking.*⁶⁹⁷

Collins and colleagues go on to note that such problems worked themselves out over the course of the program's first five years and that the keys to program success were staff attitude toward volunteers and giving the volunteers "ownership" of the program.

RELEVANT STUDIES ON PEER-BASED SERVICES FROM ALLIED FIELDS

The potential effectiveness of peer-based services draws further support from other fields of health and human services. Durlack⁶⁹⁸ and Hattie⁶⁹⁹ conducted evaluations of studies comparing the effectiveness of professional and paraprofessional counselors. In Durlack's review of 42 studies, one study found greater effectiveness among professional therapists (post-baccalaureate training in psychiatry, psychology, social work, or psychiatric nursing), and 12 studies found greater effectiveness among paraprofessional counselors (those without post-baccalaureate training), with the remaining studies finding no differences between professional and paraprofessional counselors. Durlack concluded:

Findings from 42 studies comparing the helping effectiveness of paraprofessionals and professionals are consistent and provocative. The

⁶⁹⁵ Collins, G.B., Barth, J., & Zrimec, G. (1980). Recruiting and retaining AA volunteers in a hospital alcoholism program. *Hospital and Community Psychiatry*, 32(2), 130-132.

⁶⁹⁶ Collins, G.B. & Barth, J. (1979). Using the resources of AA in treating alcoholics in a general hospital. *Hospital and Community Psychiatry*, 30(7), 480-482.

⁶⁹⁷ Collins, G.B., Barth, J., & Zrimec, G. (1980). Recruiting and retaining AA volunteers in a hospital alcoholism program. *Hospital and Community Psychiatry*, 32(2), 130-132, quote from page 131.

⁶⁹⁸ Durlak, J.A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin*, 86(1), 80-92.

⁶⁹⁹ Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 95(3), 534-541.

*clinical outcomes paraprofessionals achieve are equal to or significantly better than those obtained by professionals.*⁷⁰⁰

However, Durlack's 1979 review found only partial experimental evidence supporting the proposition that "indigenous therapists" (those similar to clients in background, lifestyle, and characteristics) generated better outcomes than did therapists who did not share such qualities with their clients. The proposition that counselors who shared their clients' culture and peer-level status would make more effective helpers⁷⁰¹ has been subsequently tested using multiple dimensions (race, gender, and religious orientation), with mixed findings.⁷⁰² The extent to which similarities in race, gender, age, religious orientation, drug choice, and recovery pathways between P-BRSS specialists and those they serve remains an important research question. (See discussion in Chapter Eight.)

Hattie's 1984 review of the comparative effectiveness of paraprofessional and professional helpers concluded:

*Effect sizes based on 154 comparisons from 39 studies indicated that clients who seek help from paraprofessionals are more likely to achieve resolution of their problems than those who consult professionals.... The more experienced the paraprofessionals, the greater their effectiveness compared to professionals.*⁷⁰³

The mental health field has used peers primarily in the role of case managers.⁷⁰⁴ Solomon and Draine⁷⁰⁵ reviewed studies comparing mental health consumer- and non-consumer-delivered case management services. They concluded that personal characteristics of the case manager, more than personal recovery history, influenced service outcomes. Other studies of peer-delivered mental health services found that consumers are well integrated into mental health service teams and achieve service outcomes equivalent to those delivered

⁷⁰⁰ Durlak, J.A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin*, 86(1), 80-92, quote from page 89.

⁷⁰¹ Pearl, A. (1981). The paraprofessional in human service. In S. Robbin & W. Wagonfeld (Eds.), *Paraprofessionals in the human services*. New York: Human Science Press.

⁷⁰² Atkinson, D.R., Maruyama, M., & Matsui, S. (1978). Effects of counselor race and counseling approach on Asian Americans' perception of counselor credibility and utility. *Journal of Counseling Psychology*, 25, 76-83.

⁷⁰³ Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 95(3), 534-541, quote from pages 534, 540.

⁷⁰⁴ Mowbray, C. T., Moxley, D. P., Jasper, C. A., & Howell, L. L. (1997). *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services (IAPSRs).

⁷⁰⁵ Solomon, P. & Draine, J. (1994). Family perceptions of consumers as case managers. *Community Mental Health Journal*, 30(2), 165-76. Solomon, P. & Draine, J. (1994). Satisfaction with mental health treatment in a randomized trial of consumer case management. *Journal of Nervous and Mental Disorders*, 182(3), 179-84.

by professionals.⁷⁰⁶ Consumer-delivered mental health services are also linked to higher levels of positive regard and understanding,⁷⁰⁷ greater contact with clients,⁷⁰⁸ and higher rates of service retention and participation.⁷⁰⁹ No differences in stress or burnout have been found in studies comparing consumer- and non-consumer-delivered mental health services.⁷¹⁰ In a recent review of this literature, Davidson and colleagues reviewed the available studies on consumer-run mental health services and concluded: "Consumer-run services can be viable organizations and can provide useful services."⁷¹¹

Peer-based services have also been positively evaluated in serving HIV+ addicted women,⁷¹² as well as addicted women with a history of neglect of their children.⁷¹³ Until studies of new P-BRSS specialists' roles can be conducted, it may be necessary to rely on existing studies that have evaluated particular functions (outreach, case management, and advocacy) within these specialist roles.⁷¹⁴

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- ⁷⁰⁶ Chinman, M.J., Rosenheck, R., Lam, J.A., & Davidson, L. (2000). Comparing consumer and nonconsumer provided case management services for homeless persons with serious mental illness. *Journal of Nervous and Mental Disorders*, 188(7), 446-53. Felton, C.J., Stastny, P., Shern, D.L., Blanch, A., Donahue, S.A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: impact on client outcomes. *Psychiatric Services*, 46(10), 1037-44.
- ⁷⁰⁷ Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric Services*, 57(8), 1179-84.
- ⁷⁰⁸ Solomon, P. & Draine, J. (1996). Perspectives concerning consumers as case managers. *Community Mental Health Journal*, 32(1), 41-6.
- ⁷⁰⁹ Dermatis, H., Galanter, M., Trujillo, M., Rahman-Dujarric, C., Ramaglia, K. & LaGressa, D. (2006). Evaluation of a model for the treatment of combined mental illness and substance abuse: The Bellevue model for peer-led treatment in systems change. *Journal of Addictive Diseases*, 25(3), 69-78.
- ⁷¹⁰ Solomon, P. & Draine, J. (1996). Perspectives concerning consumers as case managers. *Community Mental Health Journal*, 32(1), 41-6.
- ⁷¹¹ Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, 6(2), 165-187. In L. Davidson, C. Harding, & L. Spaniol, (Eds.) (2005). *Recovery from severe mental illness: Research evidence and implications for practice* (pp. 412-450). Boston: Boston University. Quote from page 172.
- ⁷¹² Boyd, M.R., Moneyham, L., Murdaugh, C., Phillips, K.D., Tavakoli, A., Jackwon, K., et al. (2005). A peer-based substance abuse intervention for HIV+ rural women: A pilot study. *Archives of Psychiatric Nursing*, 19(1), 10-17.
- ⁷¹³ Ryan, J. P., Marsh, J. C., Testa, M. F., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services. *Social Work Research*, 30(2), 95-107.
- ⁷¹⁴ Studies evaluating these elements include: Cox, G. B., Walker, R. D., Freng, S. A., Short, B. A., Meijer, L. & Gilchrist, L. (1998). Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. *Journal of Studies on Alcohol*, 523-531. McLellan, A.T., Hagan, T.A., Levine, M., Meyers, K., Gould, F., Bencivengo, M., Durell, J., & Jaffe, J. (1999). Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence*, 55, 91-103.

COMMENTARY ON LACK OF DISTINCTIVE FINDINGS

There are several striking findings from the studies reviewed in this chapter. First, most were conducted during the pre-professional stage of addiction counseling and compared non-degreed counselors in recovery with counselors not in recovery who had college or graduate degrees. Some observers have suggested that “the recovering person who has gotten himself well trained clinically has much more to offer than a therapist who is just recovering or well trained clinically,”⁷¹⁵ but studies are lacking that compare the effectiveness of recovering counselors and counselors without a history of addiction who have comparable levels of education and clinical training.

Second, these studies have focused on the counseling role with people in the earliest stages of recovery and have not included the role of recovery status in the effectiveness of long-term, non-clinical recovery support services.

Third, these studies have focused on counselors with widely varying lengths of recovery and have not evaluated the effects of length or framework of personal recovery on helping effectiveness.

The findings to-date of no major differential effects of recovery status on addiction counseling or support might mean several things. They might mean that there simply are no such effects. They might mean that such differences do exist, but these differences disappear over time due to an exchange of learning (a synthesis of experiential and professional learning) that takes place between recovering counselors and counselors who do not have a history of addiction. They might also, as suggested earlier, mean that there are differences, but these differences are suppressed via education, training, supervision, and the sustained professionalization of the recovering counselor. The state of our knowledge at this moment supports the conclusion of the Annapolis Coalition on Behavioral Health Workforce Education:

*There are multiple pathways to competence, which may include elements of personal experience, training and professional development. However, none of these pathways guarantees competence.*⁷¹⁶

In addition, the competence of addiction professionals does not by itself guarantee successful client outcomes. No one system (or program) has the resources and reach to address the total span of alcohol and other drug problems within local communities and the contextual factors that exacerbate these problems and create obstacles to long-term recovery. P-BRSS constitute a bridge between professional systems of care and the resources of the larger community—resources that must be mobilized to increase the prevalence of recovery within communities across the country.

⁷¹⁵ Flores, P.J. (1988). *Group psychotherapy with addicted populations*. New York: Haworth Press.

⁷¹⁶ Hoge, M. A., Morris, J. A., Daniels, A. S., Huey, L. Y., Stuart, G. W., Adams, N., et al. (2005). Report of recommendations: The Annapolis coalition conference on behavioral health work force competencies. *Administration and Policy in Mental Health*, 32(5/6), 651-663, quotation from p. 653.

Chapter Seven

Recent Studies of Recovery Coaching and P-BRSS

SUMMARY OF KEY FINDINGS

- Two federal programs currently administered by the Center for Substance Abuse Treatment fund initiatives that emphasize peer-based recovery support services: the Recovery Community Services Program (RCSP) and the Access to Recovery (ATR) Program.
- Studies have not been conducted to determine the effects of RCSP or ATR services on long-term recovery outcomes.
- There are independent studies of particular peer-based recovery support services that have been linked to enhanced engagement, access, treatment completion, and improved long-term recovery.

In spite of the rapid proliferation of P-BRSS specialist roles, few studies have examined the effects of these support roles on the long-term recovery outcomes of those receiving and those providing such services. In this chapter, we will briefly review what is known about the two major federal programs that have contributed to the spread of P-BRSS, as well as model state and urban peer-service initiatives. We will also look at studies that have evaluated various aspects of P-BRSS roles.

THE RECOVERY COMMUNITY SERVICES PROGRAM (RCSP)

In 1998, the Center for Substance Abuse Treatment (CSAT) began the Recovery Community Support Program—an initiative that provided federal funds to recovery community organizations to conduct recovery-focused community education and advocacy by and on behalf of recovering individuals and their families. Grantees mobilized local communities of recovery culturally and politically, increased the involvement of recovery community members in key policy discussions, launched local anti-stigma campaigns, assessed the recovery support needs of local communities, and developed programs to address those needs. Between 1998 and 2002, RCSP grantees across the country pursued these functions with growing success and visibility. Through its grantees, the RCSP initiative contributed significantly to the rise of a “new recovery advocacy movement.”⁷¹⁷

⁷¹⁷ White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

In 2002, a policy change shifted the focus of the RCSP. The program was re-titled the “Recovery Community Services Program” and shifted from the earlier focus on community education and policy advocacy to the development of non-clinical recovery support services, with a particular emphasis on peer-based recovery support services. This shift brought RCSP grantees in closer alignment with the treatment system and provided to individuals and families RCSP services that might enhance treatment and long-term recovery outcomes. The following table displays CSAT’s description of the redesigned RCSP.

CSAT’s Recovery Community Services Program (RCSP)⁷¹⁸

RCSP Goals: Under the RCSP, CSAT provides funding and support to recovery community groups and facilitating organizations to develop and deliver innovative peer-to-peer recovery support services in community settings. These services are intended to achieve the following goals:

1. Help prevent relapse
2. Promote timely re-entry into treatment when relapse occurs
3. Promote sustained recovery and an enhanced quality of life for participants

RCSP Activities: The RCSP grants are funded to conduct the following activities:

- Assess consumer, family, and other stakeholder strengths and resources, as well as community-specific recovery support needs
- Develop and strengthen collaborative relationships with other area service providers
- Develop a plan for delivering peer-to-peer recovery support services
- Deliver the services
- Document and evaluate the service program, using demographic and qualitative methods

Funding Levels: In Federal Fiscal Year 1998, CSAT presented awards to 19 projects, in the amount of \$3.6 million. In Federal Fiscal Year 2001, 21 projects received a total of \$4.8 million. In Federal Fiscal Year 2003, ten awards were made for a total of \$3.25 million. In Federal Fiscal Year 2004, eight projects received awards in the amount of \$2.8 million. In Federal Fiscal Year 2006, seven awards were made, for a total of \$2.4 million. Most recently, in Federal Fiscal Year 2007, eight awards were made, for a total of \$2.8 million. In FY 2008, no new projects were funded, and the program’s future is uncertain.

⁷¹⁸ *Recovery Community Services Program: Program overview.* Retrieved November 14, 2008 from <http://rcsp.samhsa.gov/about/overview.htm>.

Peer-based recovery support services provided by RCSP grantees include:

- peer-led recovery support groups and meetings;
- recovery coaching or mentoring;
- peer case management, information, and referral;
- recovery learning circles and other forms of recovery-related adult education;
- coaching or training in:
 - life skills,
 - health and wellness,
 - education and career planning
 - leadership skills development; and
- alcohol- and drug-free social and recreational activities.⁷¹⁹

Process evaluations have been conducted of the RCSP program that report data on service volume and the experience and lessons learned from RCSP grantees,⁷²⁰ but to-date no formal studies of the RCSP have been published in the field's scientific journals, nor have there been any independent, unpublished evaluations that included data on long-term recovery outcomes of service recipients within programs funded by the RCSP.⁷²¹ From the standpoint of science, the effects of the recovery support services provided by RCSP grantees on those served through this project are unknown.

The RCSP is evaluated primarily through benchmarks established by the Center for Substance Abuse Treatment under the Government Performance Results Act of 1993. RCSP grantees exceeded these benchmarks, with service recipients across all RCSP cites reporting an 85% abstinence rate, 62% rate of employment with no criminal involvement, and 61% living in recovery-conducive housing.⁷²²

THE ACCESS TO RECOVERY (ATR) PROGRAM

The Access to Recovery (ATR) program is a Presidential initiative begun in 2004, through which federal funds are allocated to expand the number of people receiving addiction treatment and non-clinical recovery support services in the United States. Two unique aspects of ATR include the expansion of service providers to include faith-based and other community service organizations that have not previously received public funding and a voucher

⁷¹⁹*Recovery Community Services Program: About the RCSP program.* (2006). Retrieved November 14, 2008 from <http://rcsp.samhsa.gov/about/index.htm>.

⁷²⁰*Center for Substance Abuse Treatment Recovery Community Support Program: Grantee accomplishments and lessons learned.* (2001). Retrieved November 14, 2008 from http://rcsp.samhsa.gov/_pubs/lessons_learned_2001.pdf.

⁷²¹Literature searches failed to reveal any RCSP studies in peer-reviewed journals, nor were any such studies identified by persons who have worked closely with the RCSP: Personal communications with Marsha Baker and Bonnie Veysey, November 2008.

⁷²²Recovery Community Services Program (2008) Face sheet prepared by Faces and Voices of Recovery.

program that enhances service consumer choice in selecting a service provider. The ATR program began with awards to 14 states and one tribal government in 2004, and ATR awards were granted in 2007 to 18 states, the District of Columbia, and five tribal organizations. To-date, approximately \$300 million have been allocated to ATR services.

One purpose of the ATR program was to increase access to treatment and recovery support for special underserved populations, including pregnant women; women in the child welfare system; men, women, and youth returning to the community from jails and correctional facilities; men and women involved in drug courts due to methamphetamine dependence; and those living in rural areas with limited service resources. To-date, more than 170,000 people have been served through the ATR program, which is now administered by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA).⁷²³

Like the RCSP, there have been no studies of the ATR program published in peer-reviewed, scientific journals. However, ATR grantees do report service data through the SAMHSA Services Accountability Improvement System (SAIS). SAIS data answer at least some critical questions related to the ATR program. First, services provided through ATR have gone beyond traditional treatment services: 63% of ATR clients have received recovery support services, and a total of 48% of all ATR dollars have been used for recovery support services. Second, the goal of expanding the treatment and recovery support network is being achieved: 31% of ATR dollars have gone to faith-based organizations.

The long-term effects of ATR services are more difficult to determine. This question involves the extent to which these services facilitate the early interruption of addiction careers, enhance recovery initiation and stabilization, sustain recovery maintenance, and enhance quality of life in long-term recovery. Of these four dimensions, reports are available to answer only the second dimension, recovery initiation and stabilization. The SAIS data provided by ATR grantees document the following key findings:

- 71.4% of ATR clients were abstinent at discharge from service.
- At discharge, 22.3% of clients with housing problems at intake had resolved these problems.
- 29.3% of clients unemployed at intake had achieved employment by discharge.
- 59.5% of clients who were not connected to social support for recovery had achieved such connection by discharge.
- 84.7% of clients involved with the criminal justice system were no longer involved at discharge.⁷²⁴

The extent to which these gains were sustained following discharge is unknown.

⁷²³ SAMHSA *Access to Recovery (ATR) grants: 2007 ATR factsheet*. (2007). Retrieved November 14, 2008 from <http://atr.samhsa.gov/Factsheet07.aspx>. *State ATR program descriptions*. (2007). Retrieved from <http://atr.Samhsa.gov/stateprograms.aspx>.

⁷²⁴ *ATR Aggravated Data Profile*. (2007). Retrieved November 14, 2008 from http://atr.samhsa.gov/downloads/aggregate_march07.pdf.

Mangrum conducted one of the few evaluation reports of ATR.⁷²⁵ This study of ATR services in Texas between 2004 and 2007 drew several important conclusions. First, ATR clients entered treatment with less severe substance-related problems than did non-ATR clients—a factor that may have contributed to the finding that ATR clients achieved better treatment completion rates and abstinence-at-discharge rates than non-ATR clients achieved. Another factor that may have influenced these positive outcomes is the fact that ATR clients tended to stay in treatment longer. The best intermediate recovery outcomes were achieved by clients who received support services directly linked to recovery initiation and stabilization: recovery coaching, recovery support groups, and relapse prevention training. Support services such as housing, transportation, and employment coaching were unsuccessful in the absence of addiction treatment. Again, the extent to which the gains achieved through participation in ATR services are sustained in the months and years following treatment is unknown.

STUDIES OF SERVICE ELEMENTS RELATED TO P-BRSS

The lack of studies of the major P-BRSS initiatives at the federal, state, and local levels makes it difficult to respond to questions related to the effectiveness of such services. There have, however, been studies of particular functions or elements within P-BRSS that can cast light on their potential value. Representatives of such studies include the following.

- **Outreach:** Project SAFE in Illinois successfully used outreach workers to engage hard-to-reach women with histories of addiction and child neglect.⁷²⁶ Coviello, Zanis, Wesnoski, and Alterman⁷²⁷ used an outreach intervention delivered by bachelor's-level case managers to successfully re-engage methadone clients who had relapsed following their discharge from treatment.⁷²⁸

⁷²⁵ Mangrum, L. (2008). *Final Evaluation Report: Creating access to recovery through Drug Courts*. Texas Department of State Health Services, Mental Health and Substance Abuse Services Division. Austin, Texas: Gulf Coast Addiction Technology Transfer Center.

⁷²⁶ White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

⁷²⁷ Coviello, D.M., Zanis, D.A., Wesnoski, S.A., & Alterman, A.I. (2006). The effectiveness of outreach case management in re-enrolling discharged methadone patients. *Drug and Alcohol Dependence*, 85, 56-65.

⁷²⁸ Also see: Bradford, J.B. (2007). The promise of outreach for engaging and retaining out-of-care persons in HIV medical care. *AIDS Patient Care STDS*, Supplement 1, 21, S85-91. Fisk, D., Rakfeldt, J. & McCormack, E. (2006). Assertive outreach: An effective strategy for engaging homeless persons with substance use disorders into treatment. *American Journal of Alcohol and Drug Abuse*, 32(3), 479-86. Rahimlan, A. & Pach, A. (1999). Stories of AIDS outreach and case management: Context and activities. *Substance Use and Misuse*, 34(14), 1991-2014.

- Recovery Coaching: Klein, Cnaan, and Whitecraft⁷²⁹ studied a peer support program for people with co-occurring psychiatric and substance use disorders. Those who received the services of a “friend’s connector” (peer recovery coach) had dramatically fewer crises and hospitalizations, less alcohol and drug use, improved living circumstances, enhanced income, and enhanced health compared to those who did not receive recovery coaching. Ryan, Marsh, Testa, and Louderman (2006) found that the use of recovery coaches to help integrate addiction treatment and child welfare services for parents in substance-involved families enhanced access to treatment and resulted in increased rates of family reunification.
- Case Management: Case management has been found to improve addiction treatment engagement, treatment completion, and long-term recovery outcomes in adults and adolescents.⁷³⁰
- Supplemental Services: Increased ancillary medical and social services in addiction treatment have been consistently linked to enhanced recovery outcomes across treatment modalities.⁷³¹
- Recovery Checkups: Recent studies have confirmed the utility of post-treatment recovery checkups (monitoring, support, re-intervention, re-linkage to treatment) on long-term recovery outcomes for adults⁷³² and

⁷²⁹ Klein, A., Cnaan, R., & Whitecraft, J. (1998). Significance of peer social support for dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, 8, 529-551.

⁷³⁰ Siegal, H.A., Rapp, R.C., Kelliher C.W., Fisher, J.H., Wagner, J.H., & Cole, P.A. (1995). The strengths perspective of case management: A promising inpatient substance abuse treatment enhancement. *Journal of Psychoactive Drugs*, 27(1), 67-72. Siegal, H.A., Rapp, R.C., Li, L., Saha, P., & Kirk, K. (1997). The role of case management in retaining clients in substance abuse treatment: An exploratory Analysis. *Journal of Drug Issues*, 27(4), 821-831.

⁷³¹ Berkman, N.D. & Wechsberg, W.M. (2007). Access to treatment-related and support services in methadone treatment. *Journal of Substance Abuse Treatment*, 32, 97-104. McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. F., & O’Brien, C. P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, 269(15), 1953-1959. McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, 93(10), 1489-1499.

⁷³² Cacciola, J. S., Camilleri, A. C., Carise, D., Rikoon, S. H., McKay, J. R., McLellan, A. T., et al. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford Center Focused Continuing Care protocol. *Addictive Behaviors*, 33, 1208-1216. McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100(11), 1594-1610. McKay, J.R., Lynch, K.G., Shepard, D.S., & Pettinati, H.M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry*, 62(2), 199-207. Scott, C. K. & Dennis, M. L. (in press). Results from two randomized clinical trials evaluating the impact of Quarterly Recovery Management Checkups with adult chronic substance users. *Addiction*. Scott, C. K., Dennis, M. L., & Foss, M. A. (2005). Recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, 78, 325-338.

adolescents.⁷³³ The studies have not reported on the recovery status of those conducting the face-to-face or telephone recovery checkups, so the degree to which these effects would be sustained or even enhanced within a peer delivery model is unknown.

Positive studies of key service elements provided by recovery coaches suggest that P-BRSS is a potentially promising practice as an adjunct to addiction treatment. Any determination of the extent to which P-BRSS can elevate long-term recovery outcomes will require additional studies of such services. Suggestions for such future research are outlined in the next chapter.

⁷³³ Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32. Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, 102, 81-93.

Chapter Eight

A P-BRSS Research Agenda

SUMMARY OF KEY POINTS

- There are increased calls for a recovery-focused research agenda capable of illuminating the prevalence, pathways, styles, and stages of long-term individual/family recovery from severe AOD problems.
- Research on naturally occurring recovery communities is best conducted with the sensitivities and methods recently developed for the study of other ethno-cultural communities.
- A research agenda related to P-BRS and P-BRSS must encompass expanded research on the effectiveness of recovery mutual-aid societies (particularly non-12-Step recovery support groups); the role of other recovery community support institutions in long-term recovery; the influence of recovery representation at board, executive, staff, and volunteer levels on recovery outcomes of service consumers; individual factors affecting the degree of effectiveness of P-BRSS; the effectiveness of particular P-BRSS across the stages of recovery; the relative potency of key recovery support service ingredients; the relationship of P-BRSS to professional treatment; the effects of P-BRSS on family health and functioning; and the influence of organizational context on the effectiveness of P-BRSS.
- Research should also identify the major sources of resistance to P-BRSS and the most effective methods of implementing P-BRSS.
- The recovery research agenda must encompass studies of recovery at individual, family, and community levels.

TOWARD A RECOVERY RESEARCH AGENDA

The author has argued through a long series of publications that pathology- and intervention-focused research agendas within the addiction field must be substantively extended to encompass a recovery-focused research agenda.⁷³⁴ Such an agenda would plot the long-term pathways, styles, and

⁷³⁴ White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery. White, W. (2007). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at: http://www.facesandvoicesofrecovery.org/pdf/White/White_neurobiology_2007.pdf. White, W.L. & Chaney, R.A. (2008). Intergenerational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know. Posted at

stages through which severe AOD problems are resolved within individuals, families, and communities and extract lessons that could guide the design of clinical treatment and non-clinical recovery support services.⁷³⁵ It would also evaluate the role of peer-based recovery support services in long-term addiction recovery. In this chapter, we will explore some of the questions that should be addressed related to P-BRSS within this larger recovery research agenda.

COMMUNITIES OF RECOVERY AS ETHNO-CULTURAL COMMUNITIES

There are important parallels between communities of color and communities of recovery. Recovery research that involves investigation of recovering people, communities of recovery, and recovery community institutions should be informed by the historical role of research in communities of color. White and Sanders describe this role.⁷³⁶

People of color and communities of color have been wounded in a number of ways by culturally dominant research studies. They have been subjected to grossly unethical research practices (e.g., withholding medical treatment from 399 African American sharecroppers in the Tuskegee Syphilis Study). They have been stereotyped via reports characterizing the presence or absence of AOD problems in terms of racially dictated, biological vulnerability—from the “firewater” myths of racial vulnerability of Native Americans⁷³⁷ to the myth of racial invulnerability of Asians.⁷³⁸ They have been wounded by the assumption of universal applicability—the misapplication of research findings from studies in which no people of color were included. Communities of color have been injured by bad (“junk”) science, such as the now-discredited, sensationalist literature on crack cocaine and “crack babies” that turned the criminal justice and child welfare systems into occupying institutions within poor communities of color.⁷³⁹ They have been shamed by research designs and interpretations that dramatized the problems within

www.facesandvoicesofrecovery.org. White, W. & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, 19(2), 20-25.

⁷³⁵ Laudet, A.B. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusion and future directions for service development and research. *Substance Use and Misuse*, 43(12), 2001-2020.

⁷³⁶ White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, 26(3), 365-395.

⁷³⁷ Leland, J. (1976). *Firewater myths: North American Indian drinking and alcohol addiction*. New Brunswick, New Jersey: Rutgers Center of Alcohol Studies. Westermeyer, J. (1974). “The drunken Indian:” Myths and realities. *Psychiatric Annals*, 4(11), 29-36.

⁷³⁸ O'Hare, T. & Tran, T.V. (1998). Substance abuse among Southeast Asians in the U.S.: Implications for practice and research. *Social Work in Health Care*, 26(3), 69-80.

⁷³⁹ Frank, D.A., Augustyn, M., Knight, W.G., Pell, T., & Zuckerman, B. (2001). Growth development and behavior in early childhood following prenatal cocaine exposure: A systematic review. *Journal of the American Medical Association*, 285, 1613-1625.

communities of color while ignoring their strengths and resiliencies.⁷⁴⁰ Observers from within ethnic communities have also been very critical of how communities of color have been used as a valuable resource to enrich individual careers and institutions in exploitive processes that returned nothing to communities of color.⁷⁴¹ ...Given this history, scientists and scientific institutions bear a continued burden of proof regarding their safety, relevance, and benefit to communities of color. Achieving such credibility will require, at a minimum, the inclusion of community of color leaders and members in the design, conduct, interpretation, and dissemination of research and evaluation studies.⁷⁴²

The conduct of research in communities of recovery requires similar levels of sensitivity toward the potential for harm and strategies for achieving credibility within those communities.

More than ever, ethnocultural communities demand that research occur in their communities under their direction and control. Researchers should be prepared to collaborate with communities, share results that have practical value, and accept the conditions imposed by the community in gaining access to information and respondents.⁷⁴³

As we proceed into this chapter, we will try to identify some of the most critical questions whose answers will shape the future of peer recovery support services. These lists are by no means comprehensive, but they do convey some of the basic questions for which we currently lack answers.

⁷⁴⁰ Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance, resilience and recovery*. Colorado Springs, CO: White Bison, Inc.

⁷⁴¹ Casas, J.M. (1992). A culturally sensitive model for evaluating alcohol and other drug abuse prevention programs: A Hispanic perspective. In M.A. Orlandi (Ed.), *Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities* (pp. 75-116). Rockville, MD: Office of Substance Abuse Prevention.

⁷⁴² Hermes, M. (1998). Research methods as a situated response: Towards a First Nations' methodology. *Qualitative Studies in Education*, 11(1), 155-168.

⁷⁴³ Trimble, J.E. (2008). Commentary: No itinerant researchers tolerated: Principled and ethical perspectives and research with North American Indian communities. *ETHOS*, 36(3), 380-383.

RESEARCH ON RECOVERY MUTUAL-AID GROUPS

There is an extensive list of unanswered research questions related to addiction recovery mutual-aid groups. The following are among the most important to the future of P-BRSS linked to addiction treatment.

- Can the findings of research on AA be applied to other 12-Step programs and to explicitly religious and secular recovery support groups?
- How do affiliation and long-term recovery rates differ across and within mutual-aid groups representing religious, spiritual, and secular frameworks of recovery?
- What mechanisms of change are common across existing addiction recovery mutual-aid groups, and which are distinctive to particular frameworks of recovery?
- Is there scientific evidence of inadvertent harm resulting from participation in a recovery support group? If so, how might harm be minimized? Are certain types of groups contraindicated for particular types of individuals/families?
- What is the influence of having multiple choices of recovery support fellowships on rates of affiliation, participation, and long-term recovery?
- What interventions increase initial affiliation rates, reduce early dropout rates, and enhance long-term participation in recovery mutual-aid groups?
- What happens to those people who drop out of recovery support group involvement after varying lengths of participation? Do these effects vary across populations and recovery support groups?
- Does concurrent participation in more than one recovery support group generate additive or antagonistic effects?
- Are the effects of combining professional counseling, peer-based recovery coaching, and participation in recovery mutual-aid fellowships greater than the effects of participating in only one of these respective elements?
- Do the effects of participation in recovery mutual-aid groups vary for clients involved in different treatment modalities/levels of care?
- Are there particular populations for whom recovery mutual-aid group involvement might constitute an alternative to professionally directed treatment services?
- How do levels and styles of participation in recovery mutual-aid groups differ across ethnic and cultural groups? Are additive or synergistic effects achieved when recovery mutual-aid participation is combined with participation in religious/cultural revitalization movements and/or traditional healing practices?
- Are there special support groups or peer support mechanisms that enhance recovery rates for people with addiction histories re-entering communities from jail or prison?

PARTICIPATION IN OTHER RECOVERY COMMUNITY INSTITUTIONS

Non-clinical recovery support services have generally been defined in terms of recovery support groups such as AA, but as we have outlined in this monograph, recovery support services are becoming much more diverse and are being combined in unique ways. Recovery homes in the Oxford House network currently constitute the most often-studied recovery community institution other than AA/NA. There is a need for parallel research on recovery community organizations, recovery-oriented media and leisure activities, volunteer programs, recovery social clubs, recovery industries, recovery schools, and recovery ministries/churches. These studies should address such questions as:

- What are the effects of participation in these respective institutions on long-term recovery outcomes for individuals and family members?
- How does involvement in recovery support institutions influence key dimensions of recovery: abstinence rates, elevations in global health and functioning, community re-integration, and citizenship?
- Does participation in recovery community institutions reduce the risk of injury to others, e.g., threats to the safety of family members, threats to public safety, criminality, or the social burden related to addiction-related costs?
- Do the growth of recovery community institutions and the more public visibility and growth of communities of recovery change public and policy-maker attitudes and create a more recovery-friendly public policy environment?
- Are post-treatment recovery outcomes enhanced by adding one or more of these recovery support ingredients to professional treatment?
- Are there particular combinations of service/support elements that generate dramatically enhanced effects on recovery outcomes (the psychosocial equivalent of the AIDS cocktail)?

RECOVERY REPRESENTATION IN PROFESSIONAL TREATMENT

The bulk of professional literature on people in recovery working in addiction treatment dates from the 1970s and early 1980s—the “paraprofessional” and early professionalization stages of addiction counseling. The call for “recovery-oriented systems of care” and “authentic recovery representation” within such systems is once again raising questions about the roles recovering people fill within the addiction treatment field and its local organizations. Here are a few of the most basic questions that should be answered.

- What is the level of individual/family recovery representation at the board, executive, management, direct service, and volunteer levels of organizations whose mission includes the planning, funding, delivery, or evaluation of addiction treatment and recovery support services?

- To what extent do those recovery representatives reflect the diversity of American communities of recovery in terms of gender, age, ethnicity, sexual orientation, and recovery pathways?
- Given the increased homogenization of pre-service education and training and professional socialization, are there significant differences between the effectiveness of recovering addiction counselors and that of counselors without a history of addiction (as measured by recovery outcomes of assigned clients)?
- How does the risk of relapse (and other areas of work-related impairment) for recovering addiction counselors and P-BRSS specialists compare to the risk of other types of occupational impairment for counselors and P-BRSS specialists who do not have a history of addiction?
- Is the risk of relapse for the recovering counselor working in addiction treatment different from addiction counselors' risk of relapse for other chronic health conditions (e.g., cancer, asthma, diabetes, heart disease)?
- How does the recovery status of recovering people with post-baccalaureate training in psychiatry, psychology, social work, and psychiatric nursing effect service outcomes of clients treated by these individuals?

PERSON-SPECIFIC FACTORS AFFECTING RECOVERY OUTCOMES

Studies that have attempted to match particular treatments to the demographic and clinical characteristics of clients entering addiction treatment have not generated support for the many matching hypotheses that have been proposed.⁷⁴⁴ But the lack of matching effects in one arena (professionally directed treatment) does not mean that significant matching effects might not exist in another arena (peer-based recovery support services). Key research questions related to such person-specific factors include the following:

- What client characteristics are linked to the most successful P-BRSS-related recovery outcomes?
- Are there populations for whom P-BRSS are contraindicated?
- Are there matching factors other than recovery status (e.g., age, gender, ethnicity, sexual orientation, primary drug choice, recovery pathway) that influence outcomes?
- How do the effects of P-BRSS differ, if at all, across the boundaries of gender, developmental age, race/ethnicity, sexual orientation, religiosity, primary drug, problem severity, and problem complexity?

⁷⁴⁴ Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, 58, 7-29; For a review of the lack of significant findings from treatment matching studies, see Imel, Z.E. & Wampold, B.E. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors*, 22(4), 533-543.

- Do P-BRSS generate pro-recovery effects in people who have refused to go to professionally directed addiction treatment?
- What factors (e.g., problem severity/complexity, recovery capital, frequency/intensity of cravings, and threat to self/others) might determine the level of intensity of P-BRSS that should be provided?
- What are the attitudes of individuals and families toward long-term monitoring and support? What percentage of individuals/families stay involved in the monitoring process across key temporal benchmarks (first 90 days, first year, three years, and five years)?

P-BRSS AND STAGES OF RECOVERY

If we assume that there are developmental stages of recovery that vary across clinical populations and individuals, and that service and support needs evolve through these stages, then the development of stage-specific recovery support services becomes a critical component of long-term recovery management. Here are some key questions that be answered if we are to achieve that goal.

- Are particular types of P-BRSS more effective at particular stages of recovery or within particular zones of recovery?
- What are the effects of pre-treatment P-BRSS on treatment seeking, treatment engagement, and long-term recovery outcomes?
- Would in-treatment P-BRSS enhance treatment completion rates?
- What differences in linkage rates exist between peer-based and professional-based linkage to recovery support groups?
- Do post-treatment P-BRSS lower post-treatment relapse and re-admission rates?
- What effects do P-BRSS exert on enhanced quality of life in long-term recovery?
- Are there P-BRSS that lower the risk of late-stage relapse in recovery (e.g., relapse after ten or more years of stable sobriety)?

P-BRSS SERVICE ROLES

As noted in earlier chapters, new recovery support roles are being created and widely replicated within recovery community organizations; addiction treatment institutions; and allied mental health, child welfare, public health, and criminal justice agencies. Questions that are arising related to these roles include the following:

- What characteristics of P-BRSS specialists are linked to enhanced recovery outcomes?
- What is the current profile of recovering people working in non-clinical recovery support roles?

- Do recovery outcomes differ by the duration or quality of recovery of those providing professional treatment or P-BRSS?
- How can stability and quality of recovery be measured in the screening of those wishing to provide P-BRSS?
- Do recovery outcomes differ by recovery pathway (religious, spiritual, secular) of the professional or P-BRSS helper?
- Are there differences in recovery outcomes when P-BRSS are delivered in voluntary versus paid roles?
- Do family members in recovery bring knowledge, experiences, and skills that uniquely qualify them for the delivery of P-BRSS? For example, would a randomized, controlled trial of P-BRSS by AA members, Al-Anon members, and persons not in personal or family recovery generate different recovery outcomes among those with whom they work?
- What are the most frequent ethical dilemmas encountered in the delivery of P-BRSS? How do P-BRSS specialists respond to ethical dilemmas that arise during service delivery?

SERVICE INGREDIENTS AND RECOVERY OUTCOMES

The spectrum of services offered within the umbrella of P-BRSS is extensive and ever-growing. Basic questions related to these service ingredients include the following:

- What are the precise mechanisms through which P-BRSS exert an influence on recovery outcomes?
- What are the most potent ingredients within P-BRSS?
- How do the frequency and sequencing of P-BRSS affect recovery outcomes?
- How does the duration of P-BRSS affect long-term recovery outcomes? (Research confirms that recovery does not become durable—the point at which the risk of future lifetime relapse drops below 15%—until five years of continuous recovery.⁷⁴⁵ Should P-BRSS, at least in the form of annual recovery check-ups, be extended for five years?)
- How long can people be voluntarily engaged in post-treatment monitoring and support?
- What specialized P-BRSS protocols are indicated for key populations: for example, persons with extensive history of post-treatment relapse, persons consuming inordinate levels of system resources, persons living in zip codes indicating high AOD saturation?

⁷⁴⁵ For a review, see White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

- Can P-BRSS reduce future health care costs, including reducing or eliminating the costs of future episodes of acute-care addiction treatment?
- Do P-BRSS reduce threats to public safety when they are provided to groups that pose such threats, such as multiple DUI offenders?
- What differences in effects, if any, exist among different P-BRSS delivery media (face-to-face, telephone-based, Internet-based services)?
- What are the respective contributions to recovery of peer-based intrapersonal, interpersonal, and environmental interventions?
- What benefits, if any, are added when peer helpers are included within professional service teams (for example, effects on performance of professional staff, additive effects of peer/professional collaboration)?

INTERACTION BETWEEN P-BRSS AND PROFESSIONAL TREATMENT

The ideal relationship between P-BRSS and professionally directed addiction treatment has yet to be scientifically validated. Questions concerning this relationship include the following:

- Under what circumstances might P-BRSS stand as an alternative rather than an adjunct to professionally directed addiction treatment?
- Are there additive or synergistic effects when P-BRSS and professionally directed addiction treatment are combined?
- Do the effects of P-BRSS on recovery outcomes differ when they are combined with different treatment modalities and levels of care?
- How would the infusion of P-BRSS into methadone maintenance treatment and other medication-assisted treatment affect long-term recovery outcomes?
- Can pre-treatment outreach and engagement expand the number of people entering addiction treatment for the first time?
- Does the source through which a person hears about or accesses P-BRSS influence recovery outcomes?
- Does the delivery of P-BRSS in tandem with addiction treatment increase treatment dose, treatment completion rates, rate of linkage to recovery support groups, and participation in post-treatment continuing care services?
- Does the delivery of P-BRSS following addiction treatment lower post-treatment relapse rates and speed recovery re-stabilization for those who do lapse/relapse?

P-BRSS AND FAMILY/COMMUNITY RECOVERY OUTCOMES

Our need to study the potential of P-BRSS transcends questions about individual recovery outcomes.⁷⁴⁶

Research on the effects of addiction recovery on the family challenges the expectation that families rapidly regain health following recovery initiation.⁷⁴⁷ Family structure, roles, relationships, rules, and rituals are dramatically altered through the process of addiction and must be abandoned and reformed in recovery.⁷⁴⁸ This stressful family re-adjustment process has been depicted as the “trauma of recovery.”⁷⁴⁹ The chaotic family environment of the addiction years continues into the early years of recovery. Without support, this adjustment threatens both the marital relationship and family stability.⁷⁵⁰

Such findings suggest the need for family-focused P-BRSS, particularly family-focused recovery checkups, recovery education, and recovery support, that extends at least through the early years of recovery initiation and stabilization. Due to the intrapersonal orientation of current models of addiction treatment, most P-BRSS models tend to focus on services to individuals. There are, however, calls for the development of peer service models aimed at increasing family and community recovery capital.⁷⁵¹ Critical research questions related to such strategies include the following:

- What effects do family-focused P-BRSS exert on key recovery measures (for example, reducing the number, duration, and intensity of relapse episodes; enhancing long-term recovery outcomes, including increases in global health)?
- What effects do family-focused P-BRSS exert on key measures of family health and functioning (family roles, family rules, family rituals, subsystem relationships, and boundary transactions with extended kinship and community support networks)?

⁷⁴⁶ Quote below excerpted from White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

⁷⁴⁷ Brown, S. & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

⁷⁴⁸ White, W. & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, 23(4), 3-38.

⁷⁴⁹ Brown, S. & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford. See also Schmid, J. & Brown, S. (2008). Beyond “happily ever after”: Family recovery from alcohol problems. *Alcoholism Treatment Quarterly*, 26(1/2), 31-58.

⁷⁵⁰ Brown, S. & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

⁷⁵¹ White, W. & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, 23(4), 3-38. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58.

- What influences, if any, do P-BRSS exert on the intergenerational transmission of AOD problems? Do P-BRSS services targeting one family member lower the risk that other family members will develop substance use disorders, or enhance the prognosis for recovery among other family members who develop such disorders?
- Does the delivery of family-focused P-BRSS reduce indicators of family strain and disorganization (health challenges of individual family members, divorce rates, reports of child abuse/neglect, placement of children outside the home, or truancy rates of children)?
- Does the development of formal P-BRSS in a community elevate or weaken the service ethic within local communities of recovery?
- Is there a recovery “tipping point” at which saturating P-BRSS in a certain community area reduces the prevalence of addiction in that area?

Research studies are needed on the effects of family-focused P-BRSS models compared to individual-focused P-BRSS and the absence of P-BRSS.

ORGANIZATIONAL CONTEXTS AND P-BRSS OUTCOMES

P-BRSS are being provided through a variety of organizational contexts. Key research questions related to the influence of these contexts include the following:

- Are there differences in recovery outcomes across different P-BRSS delivery sites, e.g., addiction treatment programs versus recovery community organizations?
- Do recovery outcomes differ across for-profit and not-for-profit P-BRSS providers?
- What are the potentials and pitfalls of forging relationships between professional treatment organizations and indigenous recovery community organizations?
- What are the most viable financing models for P-BRSS?
- What are the possible cost offsets that can be achieved through P-BRSS (including future addiction treatment and health care costs)?
- How can government actions help or harm the development of indigenous recovery community organizations?
- Do governmental interventions that reduce discrimination and improve employment and housing opportunities influence recovery outcomes?
- What are the effects of accepting particular types of funding on the character of indigenous recovery community or faith-based organizations?

CONCERNS ABOUT P-BRSS

We also need research on the processes of implementing P-BRSS within different service systems. Arguments against P-BRSS shared with the author during training and consultation events are listed in the table that begins below, along with brief commentary related to each.

Table 11: Concerns about P-BRSS Raised by Addiction Professionals, Treatment Administrators, and Members of the Recovery Community

Concern/Contention about P-BRSS	Brief Commentary
We're already "recovery-oriented." Why do we need to add P-BRSS?	The current system of addiction treatment in the United States can achieve acute biopsychosocial stabilization more safely and effectively than it has ever been achieved in history. Rigorous reviews of treatment system performance data ⁷⁵² suggest that most clients with high problem severity/complexity and low recovery capital are not extending these brief sobriety experiments into sustainable recovery. P-BRSS are an effort to, in part, enhance and protect the transition from recovery initiation to stable recovery maintenance and enhanced quality of life in the community. Whether P-BRSS can increase the likelihood of a successful transition must be definitively answered through methodologically rigorous studies.
The popularity of P-BRSS is the first step toward the de-professionalization and de-funding of addiction treatment.	P-BRSS are an alternative to professionally delivered addiction treatment services only for those individuals with low-to-moderate problem severity and very high recovery capital. Beyond that, these services are best viewed as adjuncts or enhancements to professional services. Given the tenuous, probationary status of addiction treatment as a cultural institution, it will be important to guard against any political effort that views P-BRSS as a cheap replacement for professionally directed treatment. At the same time, addiction treatment leaders must avoid overselling the likelihood that brief episodes of professional treatment will generate sustainable recovery for most clients when such treatment is not combined with sustained post-treatment monitoring and support.

⁷⁵² White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.

Concern/Contention about P-BRSS	Brief Commentary
No one will pay for P-BRSS. Funding for these services must come out of existing dollars allocated for treatment services. More P-BRSS means less treatment.	P-BRSS are one part of the shift from viewing addiction as an acute problem to viewing it as one that can be managed like other chronic conditions. That means the provision of a longer continuum of pre-treatment, in-treatment, and post-treatment recovery support services to bolster and sustain the effects of professional treatment, reducing health care and other costs because of enhanced recovery rates and lowering treatment re-admission rates. Because of this, federal and state governments are funding P-BRSS or organizations that deliver them, and third-party payors are reimbursing for P-BRSS, either through enhanced case rates that include P-BRSS or through capitated contracts specifically for P-BRSS, and through self-pay to the organizations delivering these services. Under conditions of fixed or declining resources, increasing funding for P-BRSS might result in decreased funding for professional treatment services. However, it might also result in the allocation of more funding to professional treatment because of better recovery outcomes. The policy question concerns the combination of services that reflects the best stewardship of resources in terms of personal, family, and community benefits and the quantity and quality of recovery outcomes.
If I am no longer the expert (as a professional not in recovery), why did I spend all that time and money going to school? What does this P-BRSS trend bode for my professional future? I sometimes feel like my expertise is not respected by those advocating P-BRSS.	A premise of P-BRSS is that traditional clinical services are critical for many of the more than 20 million Americans who have yet to find recovery, but that for many of these people, professional treatment alone will not enable them to achieve and sustain long-term recovery. The effects of professional services may be dramatically enhanced when they are combined with P-BRSS. Studies of long-term recovery may also reveal that professionals have significant contributions to make during the later stages of recovery, when emotional and family distress peak and when many people in recovery consciously reshape their character and significant relationships.⁷⁵³

⁷⁵³ This potential benefit is evident from the increase in AA members who received some form of treatment or counseling after coming to AA—up from 40% in 1980 to 65% in 2004. In the latest survey, 84% of AA members reported that the professional help they received had played an important role in their recovery. Maxwell, M.A. (1984). *The Alcoholics Anonymous experience*. New York: McGraw-Hill Book Company. Alcoholics Anonymous (2005). *Alcoholics Anonymous 2004 membership survey*. New York: A.A. World Services.

Concern/Contention about P-BRSS	Brief Commentary
P-BRSS are the equivalent of practicing medicine without a license. We professionalized the role of the addiction counselor in the first place to avoid just this problem.	Clear role delineation, sound training, and rigorous and sustained supervision will be needed to ensure that P-BRSS specialists practice only within the boundaries of their education, training, and experience. It is critical that P-BRSS specialists not cross the boundary separating non-clinical and clinical services.
People in recovery are not stable enough to withstand the rigor of work in addiction treatment; they will create problems due to absenteeism, poor performance, relapse, and high position turnover.	"Indigenous workers are no panacea, but properly trained, and properly used, they can be an important new force..." ⁷⁵⁴
P-BRSS will result in harm to people who really need help, because these peers or paraprofessionals' involvement will lower competency standards and increase the number of breaches in ethical conduct. Hiring people in recovery will hurt the professional reputation of our organization.	There is no evidence that P-BRSS cause more harm than professional treatment. Everyone seeking to help individuals and families recover should be committed to minimizing risk of harm. For P-BRSS, that means defining the core knowledge and skills of P-BRSS specialists, creating ethical guidelines specific to P-BRSS roles, and providing training and supervision that ensures competency and adherence to ethical standards.
P-BRSS specialists are just "paid sponsors." Why are we paying someone to do what is freely available from local recovery support groups? Won't bringing money into this weaken the service ethic within the recovery community?	A sponsor is different from a recovery coach, and their roles must be delineated clearly by every organization providing P-BRSS. ⁷⁵⁵ The recovery coach can be paid or work on a volunteer basis, depending on the organization with which he or she is involved. P-BRSS should not replace support provided by sponsors or other indigenous community support resources. If they do, it would cause great harm to local recovery communities and constitute a great iatrogenic effect of P-BRSS.

The sources of resistance to P-BRSS and the most effective strategies for implementing P-BRSS deserve detailed study.

⁷⁵⁴ Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

⁷⁵⁵ White, W. (2006c). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity*. Philadelphia, PA: Philadelphia Department of Behavioral Health.

Chapter Nine

Summary and Conclusions

Specialized addiction treatment grew out of the failure of the mainstream health and human service system to provide effective solutions for individuals and families experiencing alcohol and other drug problems. Today, peer-based recovery support services are growing out of the failure of addiction treatment to provide a continuum of care that is accessible, affordable, and capable of helping people with the most severe and complex AOD problems move beyond brief episodes of recovery initiation to stable long-term recovery. P-BRSS are specifically designed to reach people earlier in their addiction careers, enhance recovery initiation and stabilization, improve linkage to recovery mutual-aid groups and other recovery support institutions, facilitate the transition to successful recovery maintenance, and enhance the quality of personal and family life in long-term recovery.

But this model is not a panacea. We would do well to avoid the superficial infatuation with P-BRSS that marked the infatuation with recovering alcoholics and ex-addicts in the late 1960s and early 1970s in the rise of modern addiction treatment. The value of P-BRSS is found in identifying what specifically those in recovery bring to the helping process. David Deitch and Daniel Casriel's view of this contribution is as relevant today as it was in 1967.

There is no magic attached to any label, and we would do well to avoid creating a new vogue in the hopes of an instant solution to a complex problem. There is, instead, the necessity that helpers relate not primarily through techniques, but through humanness. And, indeed, ex-addicts have frequently indicated a marked ability to do so. But this is not because they once experienced drug addiction. It is, rather, because they completed their own recovery experiences, and emerged as men and women committed to this demanding way of life.⁷⁵⁶

Peer-based models of care can have a transforming effect on larger systems of care and on our society, by enhancing long-term addiction recovery outcomes and elevating public and professional perceptions of hope for recovery. But peer models of recovery support can also be corrupted and devoured by larger systems of care. As peer-based services are integrated into the existing treatment system or offered by free-standing independent organizations, there will be pressure to emulate the ethos of the existing treatment system, including the professional roles of counselors and others.

At the dawn of modern addiction treatment, observers suggested that one of the advantages ex-addict counselors brought to their role was that they were

⁷⁵⁶ Deitch, D. & Casriel, D. (1967). The role of the ex-addict in the treatment of addiction. *Federal Probation*, 31, 45-47.

“unencumbered by ‘professionalism’ and entanglement in bureaucracy” and were free to “interact with patients in a less formal, more spontaneous fashion than professionals.”⁷⁵⁷ Care must be taken not to over-professionalize P-BRSS roles and replicate the very conditions out of which these peer-models were spawned. It will be very important to achieve a delicate balance between peer-based and professional service models, to retain the strengths of each and manage the vulnerabilities inherent in each model.⁷⁵⁸

Delivering P-BRSS can enrich an individual’s own recovery experience, but this work can also be a threat to one’s sobriety. In P-BRSS models, service accessibility, availability in time of crisis, and continuity of contact over time constitute distinctive strengths, but also provide a potential source of over-extension and burnout for individual workers and their organizations. There is an inevitable strain between accessibility and stewardship of resources, as organizations providing P-BRSS define their recovery support capacity (How many people? How many services? How long?). P-BRSS are based on the power of mutual identification—a relationship that is personal, reciprocal, and prolonged—but these same traits are potential sources of boundary ambiguity, abuse of power, and moving beyond the boundaries of personal competence. That is why training, guidelines, and supervision are as important for P-BRSS as for professional services.

P-BRSS specialists offer a rich source of experience-based guidance on individual/family recovery management, but they may be prone to forcing the recovery of those with whom they work into the conceptual framework of their own unique recovery experience. The grassroots, generalist, and “whatever it takes” qualities of the P-BRSS role are sources of its effectiveness, but the resulting problems (e.g., role ambiguity, role conflict, lack of career mobility) can trigger the move toward role specialization, professionalization, and the commodification and commercialization of peer support.

The P-BRSS values of empowerment, autonomy, self-determination, and choice offer a distinct alternative to the role of coercion that still holds sway in many segments of specialty-sector addiction treatment. However, these same values may limit the utility of this model for individuals who pose significant threats to themselves, their families, and the community. P-BRSS models with strong advocacy and community development components offer distinct advantages over models that focus exclusively on intrapersonal change, but these very components can constitute a diversion from the immediate needs of individuals/families and can bring the agency involved in P-BRSS into conflict with powerful community institutions.

Professional service models experience a similar duality. The role specialization in professional models of care can bring unparalleled levels of expertise, but have also contributed to the service silos and fragmentation of care that have ill-served individuals and families with multiple problems. Professional

⁷⁵⁷ Suchotliff, L. & Seligman, E. (1974). The myth of the ex-addict staff. *Drug Forum*, 4(1), 47-51.

⁷⁵⁸ White, W. (2002b). *Toward a vision of peer-driven and peer-led recovery support services*. Presented at Recovery Community Support Program Conference, July 23, 2002, Washington D.C.

codes of ethics have enhanced the safety of service consumers, reduced professional liability, and ensured a degree of detachment and objectivity, but they have also contributed to rule-based decision-making that can convey fear of involvement, aloofness, snobbishness, disinterest, or contempt—particularly toward individuals hypersensitive to such slights.

The intrapersonal focus of professional service models has great individual healing power, but has often neglected families and kinship networks and the larger social pathologies in which personal problems are often embedded. The professional emphasis on accurate differential diagnosis and problem-focused service planning has aided many people, but this emphasis can lead to a preoccupation with pathology at the expense of recovery. Also, the theoretical models that help guide clinical intervention for the professional can be as blinding and biasing as the unique recovery experience of the P-BRSS specialist.

Rather than view peer-based and professional-based styles of knowing and doing as antagonistic models that must be judged against one another in terms of superiority and inferiority, it is more helpful to view these approaches as complementary, what one of the field's pioneers referred to as a "creative fusion of heart and mind."⁷⁵⁹

Peer-based recovery support services can help shift the larger treatment system from a focus on brief biopsychosocial stabilization to a focus on the long-term recovery process. Peer-based models can inject a recovery focus—a source of renewal—into treatment institutions whose fear of the current climate of financial scarcity has driven them into excessive preoccupation with paper, profit, and professional prestige.⁷⁶⁰ P-BRSS specialists can help divert excessive attention from "funding streams," "product lines," and "bottom lines" and refocus attention toward long-term recovery pathways and processes for individuals and families.⁷⁶¹

This must be done in a way that avoids the "us and them" polarizations between peer and professional models. The issue is not, "Who is more valuable: a doctor or a friend?" The issue is what individuals and families need at a particular moment in time. What people seeking recovery do not need are friends playing doctor or doctors abandoning their roles to become friends. It is not a question of one or the other. We need a community in which both are available as needed, and in which professional and peer-based services are supported and integrated into a seamless system of long-term recovery support.⁷⁶²

⁷⁵⁹ McGovern, T. (1992). Alcoholism and drug abuse counseling: A personal reflection. *The Counselor*, 10(3), 38-46.

⁷⁶⁰ Gusfield's (1982) following observation seems apt here: "problem-solving occupations are sources of their own expansion. In serving others, the welfare state serves itself." p. 17. Gusfield, J. (1982). Deviance in the welfare state: The alcoholism profession and the entitlements of stigma. *Research in Social Problems and Public Policy*, 2, 1-20.

⁷⁶¹ Jenson, J. (2001). The recovering counselor as wounded healer. *Counselor Magazine*, 2, 21-25.

⁷⁶² Kurtz, E. (1999). Commentary in "lay treatment" In. *The Collected Ernie Kurtz*, Wheeling, WV: The Bishop of Books, p. 83-90.

*Most studies of ex-users and professionals imply a juxtaposition between them. There are few studies of how the two groups interact when they work together.... The actual realities of how ex-users and professionals interact, and who learns what from whom and under what circumstances, represent an important subject for needed research.*⁷⁶³

The addictions field brings one unique quality that separates it from peer models that are rising in allied fields. It has the oldest and largest recovery mutual aid network in the world via the growth of spiritual, secular, and religious recovery mutual-aid groups and new recovery support institutions. We must be very careful that new peer-based models capitalize upon the strength of these communities of recovery rather than undermining or replacing them. Our long-term goal is not to create a larger treatment system or a new profession, but to create the physical, psychological, and social space in which recovery flourishes in local communities. The long-term goal is the establishment of recovery support relationships that are non-hierarchical, non-commercialized, and enduring in recovery-friendly communities. We must not lose our recovery community development perspective as we venture into this peer-service arena.

The historical question “Who is most qualified to treat the alcoholic” is ill-framed because it assumes a homogeneity within the label “alcoholic” and within the boundaries of particular helping roles or categories of helpers. In terms of recovery status, the question is not whether professional and peer helpers with or without a history of addiction recovery are most effective, but which helper is most effective with which person or family at a particular point in time. The latter question suggests that different categories of helpers and different individuals may be of benefit to different individuals, and to the same person at different stages of the recovery process.

*There are so many kinds of alcoholics and so many different kinds of alcoholism that perhaps no one person can qualify to treat all alcoholics, and a therapist eminently qualified to treat one type may fail completely with another (p. 121).*⁷⁶⁴

Until we have a cartography that includes recovery pathways and stages for different subpopulations with different levels of AOD problem severity, matching helpers and helpees is likely to show as few effects as studies attempting to match particular treatments to particular clients.

Recovery stages might be broadly conceived in terms of: 1) a sudden or unfolding opportunity for change, 2) a commitment to recovery experimentation, 3) recovery initiation and stabilization, 4) recovery consolidation and maintenance, and 5) enhanced quality and meaning of life in long-term recovery. I suspect we will find P-BRSS services most critical in stage 1 (via outreach and engagement), stage 2 (via charismatic encouragement and role modeling), and

⁷⁶³ Winick, C. (1990). The counselor in drug user treatment. *International Journal of the Addictions*, 25(12a), 1479-1502, quote from page 1497.

⁷⁶⁴ Block, M. (1964). Who is qualified to treat the alcoholic? Comment on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol*. 25, 121-124.

stage 4 (construction of a recovery-based identity, social network, and lifestyle). Traditional professionals may be most effective in stage 3 (facilitation of medical/psychological crisis management and stabilization) and stage 5 (providing psychotherapeutic support to resolve serious characterological defects and to enhance the quality of intimate and family relationships). In the end, we may well end up at the position Mitchell and Graham advocated in 1973: "A combination of 'square' or professional with ex-addict or paraprofessional is the logical answer to an improved service,"⁷⁶⁵ but none of us working in 1973 could have envisioned the ways in which these talents could be combined and sequenced to support long-term recovery. Thirty-five years later, we are just beginning to develop such a vision.

A PREVIEW

This monograph has left unanswered an array of questions related to how P-BRSS can be best implemented. Having set the historical, theoretical, and scientific foundation of peer recovery support services, the next monograph in this series will present a collection of papers on how such services are being implemented at the grassroots level. Announcement of the release of this monograph will be made on the web site of the Great Lakes Addiction Technology Transfer Center: www.attcnetwork.org/greatlakes.

⁷⁶⁵ Mitchell, C.D. & Graham, T.C. (1973). The paraprofessional counselor in the treatment of narcotic addiction. *Proceedings—5th National Conference on Methadone Treatment*, 5, 2e2-b55, quotation from page 254.

Appendix

Table 12: Changing Recovery Representation in the Addiction Treatment Workforce

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1960s/early 1970s	Treatment Histories: White, ⁷⁶⁶ 1998; Winick, 1991 ⁷⁶⁷	Staff roles	Therapeutic Communities	Nearly 100%		
1969	Bullington, et al. ⁷⁶⁸	Streetworkers	Boyle Heights Narcotic Project	100%		
1973	Hoffman & Miner ⁷⁶⁹	Alcoholism Counselor Trainees	Alcoholism unit of state hospital	100%		
1973	Reinstein ⁷⁷⁰	Drug Counselors	Drug abuse program in VA Hospital	100%		
1973	Kozel & Brown ⁷⁷¹	Counselors at an addiction treatment unit	Narcotics Treatment Administration	58%		

⁷⁶⁶ White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

⁷⁶⁷ Winick, C. (1990). The counselor in drug user treatment. *International Journal of the Addictions*, 25(12a), 1479-502.

⁷⁶⁸ Bullington, B., Munns, J., & Geis, G. (1969). Purchase of conformity, ex-narcotic addicts among the bourgeoisie. *Social Problems*, 16(4), 456-63.

⁷⁶⁹ Hoffman, H. & Miner, B.B. (1973). Personality of alcoholics who became counselors. *Psychological Reports*, 33, 878.

⁷⁷⁰ Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, 24(12), 839-841.

⁷⁷¹ Kozel, N.J. & Brown, B.S. (1973). The counselor role as seen by ex-addict counselors, nonaddict counselors and significant others. *Journal of Consulting and Clinical Psychology*, 41, 315.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1974	Snowden & Cotler ⁷⁷²	Ex-addict counselors	Methadone treatment program	100%		
1974	Brown, et al. ⁷⁷³	Counselors	Narcotics Addiction Treatment Administration	68%		
1974	Wehmer et al. ⁷⁷⁴	Paraprofessional alcoholism counselor trainees	Alcoholism treatment program	46%	38%	
1975	Cooke, et al. ⁷⁷⁵	47 counselor trainees	Detroit Harbor Light Alcoholism Therapist Training Program	28%		
1975	Brown & Thompson ⁷⁷⁶	Counselors	Narcotics Treatment Administration	51%		
1976	Rosenberg et al. ⁷⁷⁷	Evaluation of training of 16 alcoholism counselors	Division of Alcoholism, Boston City Hospital	38%		

⁷⁷² Snowden, L. & Cotler, S. (1974). The effectiveness of paraprofessional ex-addict counselors in a methadone treatment program. *Psychotherapy: Theory, Research and Practice*, 11(4), 331-338.

⁷⁷³ Brown, B.S., Jansen, D.R., & Bass, U.F. (1974). Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction. *American Journal of Psychiatry*, 131(2), 215-219.

⁷⁷⁴ Wehmer, G., Cooke, G., & Gruber, J. (1974). Evaluation of the effects of training of paraprofessionals in the treatment of alcoholism: A pilot study. *British Journal of Addiction to Alcohol and Other Drugs*, 69(1), 25-32.

⁷⁷⁵ Cook, G., Wehmer, G., & Gruber, J. (1975). Training paraprofessionals in the treatment of alcoholism: Effects on knowledge, attitudes and therapeutic techniques. *Journal of Studies on Alcohol*, 36, 938-948.

⁷⁷⁶ Brown, B. S. & Thompson, R. F. (1975). The effectiveness of formerly addicted and nonaddicted counselors on client functioning. *Drug Forum*, 5(2), 123-129.

⁷⁷⁷ Rosenberg, C., Gerrein, J., Manohar, V., & Liftik, J. (1976). Evaluation of training of alcoholism counselors. *Journal of Studies on Alcohol*, 37, 1236-1246.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1978	Talbott & Gillen ⁷⁷⁸	Alcoholism counselors	Inpatient treatment program	100%		
1978	Longwell et al. ⁷⁷⁹	Counselors	MMT	39%		
1978	Argerio & Manohar ⁷⁸⁰	Counselors	Traffic safety project	57%		
1979	Berger-Gross et al. ⁷⁸¹	Paraprofessionals	State hospital alcoholism unit and detox center	85%		
1980	NDATUS, 1982 ⁷⁸²	National Survey of Treatment Units	Public and private programs	81%		
1980	Connett ⁷⁸³	Counselors	Methadone treatment	44%		
1980	Winick ⁷⁸⁴	Staff	NY Therapeutic Communities	54%		

⁷⁷⁸ Talbott, J.A. & Gillen, C. (1978). Differences between nonprofessional recovering alcoholic counselors treating Bowery Alcoholics: A study of therapist variables. *Psychiatric Quarterly*, 50(4), 333-342.

⁷⁷⁹ Longwell, B., Miller, J., & Nichols, A.W. (1978). Counselor effectiveness in a methadone maintenance program. *The International Journal of the Addictions*, 13(2), 307-315.

⁷⁸⁰ Argeriou, M. & Monohar, V. (1978). Relative effectiveness of non-alcoholics and recovered alcoholics as counselors. *Journal of Studies on Alcohol*, 39, 793-799.

⁷⁸¹ Berger-Gross, V. & Lisan, S. (1979). Attitudes of paraprofessionals toward alcoholism: Setting effects. *Journal of Study on Alcohol*, 40, 514-517.

⁷⁸² National Drug and Alcoholism Treatment Utilization Survey of 1980. (1982). In R. O'Brien & M. Chafetz (Eds.), *The encyclopedia of alcoholism* (pp.). New York: Facts on File.

⁷⁸³ Connett, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, 15(4), 585-589.

⁷⁸⁴ Winick, C. (1990). The counselor in drug user treatment, *International Journal of the Addictions*, 25(12a), 1479-502.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1981	Valle ⁷⁸⁵	Counselors	Hospital-based inpatient alcoholism treatment facility	100%		
1981	Skuja ⁷⁸⁶	Alcoholism counselors	US Navy alcohol treatment facility	50%		
1981	Stephen ⁷⁸⁷	Alcohol and drug counselors	VA-funded counselor training program	92%		
1982	Camp & Kurtz ⁷⁸⁸	Counselors working in alcohol and drug treatment	1979 national survey data	No data on recovery status; 37% were non-degreed		
1982	Hubbard, et al. ⁷⁸⁹	Counselors	Tops Study	5 of 9 treatment sites reported no ex-users on staff		

⁷⁸⁵ Valle, S. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol*, 42, 783-790.

⁷⁸⁶ Skuja, A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Drug and Alcohol Dependence*, 8(1), 61-68.

⁷⁸⁷ Stephen, L.S. (1981). Pre- and post-test measurements of self-concept of trainees in an alcohol and drug counselor training program. *Journal of Alcohol and Drug Education*, 27(1), 78-80.

⁷⁸⁸ Camp, J. & Kurtz, N. (1982). Redirecting manpower for alcoholism treatment. In *Prevention, intervention and treatment: Concerns and models. Alcohol and health monograph*, (No. 3, DHHS Publication No. ADM 82-1192 pp. 371-397). Washington, D.C.: U.S. Government Printing.

⁷⁸⁹ Hubbard, R.L., Pachal, J.V., Cavanaugh, E.R., Kirkpatrick, M.G., & Richardson, J.E. (1982). *Methodology for the TOPS Treatment Study*. Research Triangle Park, NC: Research Triangle Institute.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1982	Lawson ⁷⁹⁰	Counselors	8 alcoholism treatment programs in IL	36%		
1983	Lawson et al. ⁷⁹¹	Counselors	Training institute	66%		
1983	Birch & Davis ⁷⁹²	Alcoholism counselors	National survey	57%		
1984	LoSciuto, et al. ⁷⁹³	Drug abuse counselors	16 addiction treatment programs in five cities	39%		
1984	Aiken, et al. ⁷⁹⁴	Drug abuse counselors	16 addiction treatment programs in five cities	38%		
1985	Blum & Roman ⁷⁹⁵	Occupational Program Consultant		33%		
1985-86	Ball (Cited in Winick, 1991) ⁷⁹⁶	Counselors	7 MMT programs in three cities	31%		

⁷⁹⁰ Lawson, G. (1982). Relation of counselor traits to evaluation of the counseling relationship by alcoholics. *Journal of Studies on Alcohol*, 43, 834-839.

⁷⁹¹ Lawson, G., Petosa, R., & Peterson, J. (1982). Diagnosis of alcoholism by recovering alcoholics and nonalcoholics. *Journal of Studies on Alcohol*, 43, 834-839.

⁷⁹² Birch & Davis Associates (1983). *Development of model professional standards for counselor credentialing*. Rockville, MD: NIAAA.

⁷⁹³ LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, 19(3), 233-252.

⁷⁹⁴ Aiken, L., LoSciuto, L., Ausetts, M., & Brown, B.S. (1984a). Paraprofessional versus professional drug counselors: Diverse routes to the same role. *International Journal of Addictions*, 19(2), 153-73.

⁷⁹⁵ Blum, T. & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors. *Journal of Health and Social Behavior*, 26(4), 365-378.

⁷⁹⁶ Winick, C. (1991). The counselor in drug user treatment. *International Journal of the Addictions*, 25(12a), 1479-502..

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1986	NAADAC ⁷⁹⁷	Counselors	National NAADAC Survey	75%		
1987	McGovern & Armstrong ⁷⁹⁸	Counselors	Texas Sample National Sample	70% 70%		
1987	Sobell & Sobell ⁷⁹⁹	Counselors		76%		
1989	Mulligan et al. ⁸⁰⁰	Counselors	Multiple Tx modalities	46% overall; 76% of those working in halfway houses; 76% of those working in detox programs; and 71% of those working in private inpatient programs		
1990	Williams, et al. ⁸⁰¹	Counselors	State survey in Kansas	54%		

⁷⁹⁷ NAADAC (1986). *Survey of substance abuse counselors*. Arlington, VA: NAADAC: The Association of Addiction Professionals.

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1991	Williams, et al., ⁸⁰²	Counselors			60% reported having current/past intimate relationship, parent, child or other family member with addiction	
1991	Winick ⁸⁰³	Counselors	Phoenix House	60% (compared with 80% in 1970s)		
1991	Leavy ⁸⁰⁴	Certified alcoholism counselors	Survey of addiction counselors in Ohio	39%		
1992	Shipko & Stout ⁸⁰⁵	Counselors	5 IP programs	33%		
1992	Kolpack ⁸⁰⁶	Counselors	Wisconsin Survey	46%		
1992	Banken & McGovern ⁸⁰⁷	Counselors	Texas conference participants, NAADAC leadership, and Counselor Editorial Board	37%		

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1994	Mavis & Stöffelmayr ⁸⁰⁸	Counselors	36 public addiction treatment programs	OP=9% Res=42%	OP=32% Res=46%	
1996	St. Germaine ⁸⁰⁹	Counselors	National survey	52.6%		
1997	Roman & Blum ⁸¹⁰	Counselors	450 private treatment programs	50%		
1997	Hsieh et al. ⁸¹¹	Counselors and psychologist	National Survey of NAADAC and APA	57% of addiction counselors; 13% of psychologists	11% of addiction counselors; 43% of psychologists	
1998	Roman & Blum ⁸¹²	Counselors	434 private treatment programs	Range from 33% to 53.5% across settings		
1999	Roman & Blum ⁸¹³	Counselors	400 private treatment programs	59.7%		
2002	Roman, Blum, & Johnson ⁸¹⁴	Counselors	305 private treatment programs	38%		

⁸⁰⁸ Mavis, B.E. & Stoeffelmayr, B.E. (1994). Program factors influencing client satisfaction in alcohol treatment. *Journal of Substance Abuse*, 6, 345-354.

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⁸¹² Roman, P. & Blum, T. (1998). *National Treatment Center Study: Summary Report (No. 3): Second Wave On-Site Results*. Athens, GA: Institute for Behavioral Health.

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
1998	Culbreth & Borders ⁸¹⁵	Counselors	IP and OP treatment sites	40%		
1998	Stöffelmayr et al. ⁸¹⁶	Counselors	51 treatment programs	30%		
1998	Mondlick ⁸¹⁷	Counselors	Survey of 400 certified counselors in CT	48%		
1999	Stöffelmayr et al. ⁸¹⁸	Counselors	51 Treatment programs	32%		
2001	Nevada ATTC Workforce Survey ⁸¹⁹	Counselors		34%		
2001	Montana ATTC Workforce Survey ⁸²⁰	Counselors		65%		
2001	Utah ATTC Workforce Survey ⁸²¹	Counselors		42%		
2001	Wyoming ATTC Workforce Survey ⁸²²	Counselors		38%		

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⁸¹⁹ 2001-2004 Mountain West ATTC Workforce Study.

⁸²⁰ 2001-2004 Mountain West ATTC Workforce Study.

⁸²¹ 2001-2004 Mountain West ATTC Workforce Study.

⁸²² 2001-2004 Mountain West ATTC Workforce Study.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2001	Colorado ⁸²³	Counselors		34%		
2002	Osborn & Thombs (Ohio) ⁸²⁴	Survey of addiction counselors in Ohio		37%		
2002	Kentucky ATTC Workforce Survey ⁸²⁵	Director Staff				50% 51%
2002	Florida ATTC Workforce Survey ⁸²⁶	Staff				45%
2002	Alabama ATTC Survey ⁸²⁷	Staff				44%
2002	Ball, et al. ⁸²⁸	Counselors	CTN Study	46%		
2003	Thomas et al. ⁸²⁹	Addiction counselors	1,116 counselors from MA, TN, and WA	59.6%		
2003	Delaware ATTC Workforce Survey ⁸³⁰	Director Staff				56% 36%

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⁸²⁴ Osborn, C.J. & Thombs, D.L. (2002). Clinical orientation and sociodemographic characteristics of chemical dependency practitioners in Ohio. *Journal of Teaching in the Addictions, 1*, 5-18.

⁸²⁵ RMC Corporation (2003). *Kentucky Workforce Survey 2002. Results of a statewide needs assessment of substance abuse treatment professionals*. Portland: Central East Addiction Technology Transfer Center: 53.

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⁸²⁷ Southern Coast ATTC 2002 & 2004 Workforce Survey.

⁸²⁸ Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., McSherry, T., et al. (2002). Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers. *Journal of Substance Abuse Treatment, 23*, 309-318.

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2003	NAADAC survey of early career counselors ⁸³¹	Counselors				61%
2003	Toriello & Benshoff ⁸³²	Illinois	Survey of sample of certified addiction counselors in IL	33%		
2003	Mulvey et al. ⁸³³	National substance abuse treatment workforce study		Recovery status not reported		
2004	Arkansas ATTC Workforce Survey ⁸³⁴	Director Staff				25% 60%
2004	Missouri ATTC Workforce Survey ⁸³⁵	Director Staff				13% 57%
2004	Oklahoma ATTC Workforce Survey ⁸³⁶	Director Staff				56% 57%

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⁸³⁶ Wendler, A. M., Hunt, S.C., & Murdock, T. B. (2005). *Substance abuse treatment workforce survey report 2004: Oklahoma*. Kansas City, Kansas City, MO: Mid-America Addiction Technology Transfer Center in residence at University of Missouri-Kansas City: 49.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
2004	Tennessee ATTC Workforce Survey ⁸³⁷	Director Staff Director Staff	Contract Agency Contract Agency Licensed Agency Licensed Agency			50% 61% 48% 40%
2004	New Hampshire ATTC Workforce Survey ⁸³⁸	Direct service staff		47%		
2004	New Jersey ATTC Workforce Survey ⁸³⁹	Directors Staff				50% 52%
2004	Rhode Island ATTC Workforce Survey ⁸⁴⁰	Direct service staff		25%		
2004	Vermont ⁸⁴¹	Direct service staff		46%		

⁸³⁷ RMC Corporation (2004). *Tennessee Workforce Survey 2004. Results of a Statewide Needs Assessment of Behavioral Health Professionals*. Portland, Central East Addiction Technology Transfer Center: 45.

⁸³⁸ New England ATTC Workforce Survey, 2004.

⁸³⁹ Northeast ATTC 2004 Workforce Survey.

⁸⁴⁰ ATTC-NE (2004). Rhode Island Direct Service Providers: Summary of Findings. *Workforce Survey Results*. Providence, RI: Addiction Technology Transfer Center of New England in collaboration with the New England Institute of Addiction Studies and the State of Rhode Island, Department of Mental Health: 4.

⁸⁴¹ ATTC-NE (2004). Vermont Direct Service Providers: Summary of Findings. *Workforce Survey Results*. Providence, RI: Addiction Technology Transfer Center of New England in collaboration with the New England Institute of Addiction Studies and the State of Vermont's Department of Health, Division of Alcohol and Drug Abuse Programs: 4.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
2004	Connecticut ATTC Workforce Survey ⁸⁴²	Direct service staff		51%		
2004	Massachusetts ATTC Workforce Survey ⁸⁴³	Direct service staff		32%		
2004	Maine ATTC Workforce Survey ⁸⁴⁴	Direct service staff		49%		
2004	Florida ATTC Workforce Survey ⁸⁴⁵	Directors		36%		
2003-2004	Arizona ATTC Workforce Survey ⁸⁴⁶	Directors Staff		39% 60%		
2003-2004	California ATTC Workforce Survey ⁸⁴⁷	Directors Staff		54% 63%		

⁸⁴² ATTC-NE (2004). Connecticut Direct Service Providers: Summary of Findings. Providence, RI: Addiction Technology Transfer Center of New England: 4.

⁸⁴³ ATTC-NE (2004). Massachusetts Direct Service Providers: Summary of Findings. *Workforce Survey Results*. Providence, RI: Addiction Technology Transfer Center of New England: 4.

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⁸⁴⁷ PSATTC (2004). California's Substance Abuse Workforce. *PSATTC Workforce Survey Summary Report*. Phoenix, AZ: Pacific Southwest Addiction Technology Transfer Center (PSATTC): 4.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
2003-2004	New Mexico ⁸⁴⁸	Directors Staff		17% 59%		
2004	McGovern, et al. ⁸⁴⁹	Counselors	Survey of 89 counselors			
2005	Arfken, et al. ⁸⁵⁰	Counselors	CTN Study	37.1% CTN Counselors; 62.2% Non-CTN counselors		
2005	Fuller, et al. ⁸⁵¹	Counselors	OP treatment centers in five NE states	30.2%		
2005	Knudsen, et al., 2005 ⁸⁵² 45.5%	Counselors	Survey of 2,298 counselors in public and private Tx programs	45.5%		

⁸⁴⁸ PSATTC (2004). New Mexico's Substance Abuse Workforce. *PSATTC Workforce Survey Summary Report*. Phoenix, AZ: Pacific Southwest Addiction Technology Transfer Center (PSATTC): 4.

⁸⁴⁹ McGovern, M.P., Fox, T.S., Xie, H., & Drake, R.E. (2004). A survey of clinical practices and readiness to adopt evidence-based practices: Dissemination research in an addiction treatment system. *Journal of Substance Abuse Treatment*, 26, 305-312.

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
2005	Maryland ATTC Workforce Survey ⁸⁵³	Director	Funded Agency			56%
		Staff	Funded Agency			56%
		Director	Non-funded Agency			44%
		Staff	Non-funded Agency			56%
2005	Alaska ATTC Workforce Survey ⁸⁵⁴	Directors Clinicians		13% 36%	21% 14%	
2005	Idaho ATTC Workforce Survey ⁸⁵⁵	Directors Clinicians		46% 38%	9% 14%	
2005	Oregon ATTC Workforce Survey ⁸⁵⁶	Directors Staff		13% 36%	21% 14%	
2005	Washington ATTC Workforce Survey ⁸⁵⁷	Directors Staff		44% 48%	11% 10%	

⁸⁵³ Knudsen, J. R. W. & Williams, A.M. (2005). Maryland Workforce Survey 2005; *Results of a Statewide Needs Assessment of Behavioral Health Professionals*. Portland: Central East Addiction Technology Transfer Center and Mid-Atlantic Addiction Technology Transfer Center and Central East Addiction Technology Transfer Center: 51.

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
2005	Olmstead et al. ⁸⁵⁸	Counselors	National Treatment Center Study	51%		
2005	Toriello, et al. ⁸⁵⁹	Counselors	New Orleans study	24%		
2006	Knudsen et al. ⁸⁶⁰	Counselors	253 therapeutic communities	57%		
2006	McCollum ⁸⁶¹	Counselors	Sample of addiction counselors from seven states	43%		
2006	Sias, et al. ⁸⁶²	Counselors	188 addiction counselors in VA	36%		
2006	Kirby, et al. ⁸⁶³	Counselors	253 counselors from five states	24%		
2006	Thomas & Miller ⁸⁶⁴	Counselors	84 counselors in SC	21%		

⁸⁵⁸ Duplicate of footnote 749. Do you want this in the table twice?

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Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/Family Recovery Experience
2006	Simmons et al. ⁸⁶⁵	Survey of 72 addiction counselors		46%		
2007	Knudsen et al. ⁸⁶⁶	Counselors	NIDA CTN study	44%		
2007	Knudsen, Ducharme & Roman Am J of Addict ⁸⁶⁷	Survey of 2,306 addiction counselors	42.66%-53.22% across four study subgroups			
2007	Rieckmann et al. ⁸⁶⁸	376 counselors	21% in OP 22.3% in MTT 64.5% in Res Rehab			
2008	Thomas et al. ⁸⁶⁹	Counselors	84 counselors	16% and 26% in two study groups		

⁸⁶⁵ Simons, L., Jacobucci, R., & Houston, H. (2006). Novice, seasoned and veteran counselors' views of addiction treatment manuals: The influence of counselor characteristics on manual usefulness. *Journal of Psychoactive Drugs*, 38(4), 483-91.

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