Journal of Substance Abuse Treatment 36 (2009) 146–158

Journal of Substance Abuse Treatment

Special article

The mobilization of community resources to support long-term addiction recovery

William L. White, (M.A.)*

Chestnut Health Systems, Bloomington, IL 61761, USA

Received 15 April 2008; received in revised form 10 September 2008; accepted 6 October 2008

Abstract

Models of addiction treatment that view the sources and solutions to severe alcohol and other drug (AOD) problems as rooted within the vulnerability and resiliency of each individual stand in marked contrast to models that focus on the ecology of AOD problem development and resolution via complex interactions between individuals, families, and communities. An integration of the latter model into mainstream addiction treatment would necessitate a reconstruction of the treatment–community relationship and new approaches to community resource development and mobilization. Such an integration would redefine core addiction treatment services and to whom, by whom, when, where, and for how long such services are delivered. This article draws on historical and contemporary events in the history of addiction treatment and recovery in the United States to illuminate the relationship between recovery and community. Principles and strategies that could guide the development and mobilization of community resources to support the long-term recovery of individuals and families are identified.

Keywords: Addiction recovery; Recovery management; Recovery community; Continuing care; Outreach; Community organization

> We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.
>
> -Sandra Bloom (*Creating Sanctuary*, p. 117, Bloom, 1997)

1. Introduction

The development and resolution of severe alcohol and other drug (AOD) problems involve intrapersonal, interpersonal, and broader systems-level processes, but the dominant modalities and levels of care of addiction treatment are distinctly intrapersonal in their orientation. Mainstream services seek to modify the physiology, thoughts, feelings, and behaviors of individual service consumers with little effort extended to "treat" the larger physical and relational worlds in which individual recovery efforts succeed or fail.

Several influences are converging to push this intrapersonal orientation to a more relational and systems-focused perspective. There is growing recognition that recovery initiation in institutional settings does not assure sustained recovery maintenance in natural community environments (Weisner, Matzger, & Kaskutas, 2003; Westermeyer, 1989). Addiction recovery mutual aid societies are growing in size and geographical dispersion and diversifying in their philosophical orientations (Humphreys, 2004; White, 2004), and there are historically significant recovery community-building activities, including the spread of recovery homes, recovery schools, recovery industries, recovery ministries/churches, and new recovery community organizations and service roles (Jason, Davis, Ferrari, & Bishop, 2001; Valentine, White, & Taylor, 2007; White & Finch, 2006; White, 2006b). A new grassroots addiction recovery advocacy movement is (a) calling for a reconnection of addiction treatment to the larger and more enduring process of addiction recovery, (b) advocating a renewal of

* Chestnut Health Systems, 3479 Shawn Street, Port Charlotte, FL 33980, USA. Tel.: +1 941 624 0210.
E-mail address: bwhite@chestnut.org.

0740-5472/08/$ – see front matter
doi:10.1016/j.jsat.2008.10.006

the relationship between addiction treatment institutions and the grassroots communities out of which they were birthed, and (c) extolling the power of community in the long-term recovery process (Else, 1999; Morgan, 1995; White, 2006a, 2007b).

Scientific evidence is also confirming the limitations of current intrapersonal, acute care models of addiction treatment as measured by such performance indicators as attraction, access, engagement, retention, posttreatment relapse rates, and treatment readmission rates (White, 2008). Scientists and clinical leaders are advocating that addiction treatment shift from a model of acute biopsychosocial stabilization to a model of sustained recovery management that would emulate the treatment of other chronic health conditions (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000; O'Brien & McLellan, 1996; White, Boyle, & Loveland, 2002). Interest is also growing in public health and harm reduction strategies that integrate environmental and clinical strategies of AOD problem resolution (Kellogg, 2003; Tatarsky, 2003).

Recovery is emerging as an organizing paradigm for behavioral health care policy (Department of Health and Human Services, 2003; Institute of Medicine, 2006; White, 2005), addiction and mental health services integration (Davidson & White, 2007; Gagne, White, & Anthony, 2007), federal service program initiatives (e.g., Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP) and Access to Recovery program; Clark, 2007), and state and local behavioral health care system transformation efforts (Evans, 2007; Kirk, 2007). This has in turn sparked interest in defining recovery (Betty Ford Institute Consensus Panel, 2007) and in mapping the pathways, styles, and stages of long-term recovery (White & Kurtz, 2006b). Collectively, there is growing focus on the *ecology of addiction recovery*—how the relationships between individuals and their physical, social, and cultural environments promote or inhibit the long-term resolution of severe AOD problems.

Families, kinship and social networks, and communities can be considered in need of treatment and recovery when the health and performance of its members and the system as a whole have been severely impaired by alcohol- and other drug-related problems. In this view, parallel processes exist between the wounding and healing of the individual, the family, and the community. Much of what is known about the recovery of individuals (De Leon, 1996; White, 1996) is paralleled in the recovery of families (Brown & Lewis, 1999), kinship and social networks (Galanter, Dermatis, Keller, & Trujillo, 2002), and whole communities (Williams & Laird, 1992). Table 1 depicts such parallel processes.

Individuals, families, kinship networks, and communities, through their interactions with one another, can perform both wounding and healing functions (Falkin & Straus, 2003; Schmitt, 2003). The purpose of this current article is to set forth historically grounded principles and strategies to guide the development and mobilization of community resources to facilitate recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families.

Table 1
Individual, family, and community recovery

Parallel processes in personal, family, and community recovery
1. Honest acknowledgement of AOD problems and their severity.
2. Admission that past problem-solving efforts have failed.
3. Visible expression of commitment to change.
4. Inventory of assets and vulnerabilities.
5. Development of a recovery action plan.
6. Recovery initiation, resource mobilization, and recovery stabilization.
7. Management of continuing self-defeating patterns of thinking, feeling, acting, and interacting.
8. Character and identity (story) reconstruction (who we were, what happened, who we are now and are becoming).
9. Reconciliation and reconstruction of key relationships.
10. Recovery maintenance rituals (e.g., centering rituals, sober fellowship, acts of self-care, acts of citizenship and service).

2. Historical perspectives on recovery and community

There are informative periods in the history of addiction treatment and recovery that illustrate the power of community in the recovery process and the link between community revitalization and the recovery of individuals and families.

2.1. Native American recovery movements

Coyhis and White (2006) have catalogued more than 250 years of abstinence-based religious and cultural revitalization movements among Native American tribes. For historically disempowered and besieged groups, the processes of personal/family recovery are inseparable from larger processes of religious and cultural revitalization. An individual can serve as a catalyst for community healing, and the recovery of a family or a community can widen the pathway of entry into recovery for individuals—a process vividly portrayed in the modern history of the Shuswap tribal community in Alkali Lake, British Columbia (Coyhis & White, 2006; Taylor, 1987).

The contemporary Native American Wellbriety Movement, a grassroots recovery advocacy movement started in 1999 to promote addiction recovery and wellness in American Indian communities, uses the metaphor of a *healing forest* to portray this connection between individual, family, and community. The acute, intrapersonal model of addiction treatment is portrayed as digging up a sick and dying tree, transplanting and nourishing it back to health, and then replanting it in the soil from which it came. This Wellbriety metaphor calls for moving beyond the treatment of sick trees to the creation of a healing forest in which the health of individual trees, the soil, and the environment are simultaneously elevated (Coyhis & White, 2006; The Red Road to Wellbriety, 2002).

2.2. The Washingtonians, the Keeley Leagues, Alcoholics Anonymous, and Synanon

There is a long and rich history of addiction recovery mutual aid organizations in the United States (White, 2001). Three such organizations reveal important lessons about the relationship between community and recovery (all accounts are from White, 1998). The Washingtonians, founded in 1840 as a recovery mutual aid fellowship, grew to more than 400,000 members within 48 months and then rapidly declined. One of the sources of their demise was their engulfment by the larger community (e.g., abandonment of their closed meeting structure) that diminished the mutual identification between their alcoholic members. The Washingtonian saga suggests that when recovery communities become too connected to the outside community, they are vulnerable to identity diffusion, colonization, and collapse.

The Keeley Leagues were organized as a patient support group within the Keeley Institutes—a private addiction cure institute founded in 1879 that was franchised in more than 120 locations in America and Europe. The Keeley Leagues flourished (more than 30,000 members in 370 chapters) until the founder attempted to convert the leagues from its function of recovery support to "a great advertising medium" (White, 1998, p. 57). The Keeley League saga confirms that indigenous recovery mutual aid groups can be hijacked to serve the financial interests of other community institutions and that organizational collapse is often the product of such colonization. Great care must be taken in forging the relationship between professional organizations and indigenous recovery support institutions.

Alcoholics Anonymous (AA), founded in 1935, is the largest, most geographically accessible, and most widely adapted recovery mutual aid structure in the world (Kurtz, 1979). Early in its history, AA worked out its relationship to community via formulation of its Twelve Steps (emphasizing resources and relationships beyond the self; amends to others, and service to others) and Twelve Traditions (emphasizing singularity of purpose, organizational autonomy, financial self-support, a public relations policy of attraction rather than promotion, and anonymity at the level of press; AA, 1981). One of AA's unique contributions is its ability to create a closed recovery community without isolating its members from full participation in the larger community.

Synanon was founded by Charles Dederich in 1958 as the first ex-addict-directed therapeutic community (TC) in the United States. The original vision was a three-phase experience: (a) total enmeshment within the life of the TC, (b) living in the TC while working or going to school in the community, and (c) living and working outside while returning to the TC for support. When relapses occurred during community reentry, Synanon progressively lengthened Phase 1 and eventually abandoned Phases 2 and 3. At that point, Synanon became a closed community and began its slow path to organizational self-destruction (Janzen, 2001).

The Synanon story suggests that when communities of recovery become too disconnected from the larger community, they become vulnerable to the vagaries of charismatic leadership, cult-like isolation, ideological extremism, internal schisms, breaches in ethical and legal conduct, and eventual implosion. The story of Synanon also reflects how institutions whose stated mission is to rehabilitate and return recovering addicts to their communities often end up further isolating recovering people from the natural communities within which successful long-term recovery must be firmly nested. Participation in treatment and recovery support institutions can lead to isolation from the community or serve as a bridge to greater community participation (Kurtz & Fisher, 2003).

2.3. The prohibitionist vision

The prohibition movements of the late 19th and 20th centuries grew in a climate of growing therapeutic pessimism about the prospects of long-term recovery. Those with AOD problems became demonized and cast as a threat to the health and future of American civilization. The new policy called for letting the alcohol- and drug-dependent individuals die off while preventing a new generation of AOD problems via the prohibition of the sale of alcohol and the aggressive control of opium, morphine, and cocaine (Musto, 1973).

This shift in cultural climate and its resulting policies led to the collapse of America's inebriate homes, inebriate asylums, and addiction cure institutes; the passage of mandatory sterilization laws that targeted alcohol-dependent and substance-abusing individuals as well as persons with mental illness and those who are developmentally disabled; and the sequestration of alcoholics and addicts in inebriate penal colonies and the back wards of aging state psychiatric asylums (White, 1998). When community members become frightened, those with severe AOD problems are vulnerable for scapegoating and extrusion from the community, particularly when these fears are heightened by gender, class, racial, and intergenerational conflict. This principle illustrates a potentially more ominous influence of community—the power of community to do harm to individuals and families affected by AOD problems.

2.4. Early industrial alcoholism programs

In the mid-1940s, a number of companies began involving employees who had found sobriety in AA to work with other employees experiencing alcohol-related problems. These experiments evolved into early occupational alcoholism programs, which later gave rise to "broadbrush" employee assistance programs (EAPs). The historical evolution of EAPs is instructive. These programs progressively shifted their focus from alcohol problems to

other problems, to organizational wellness, and then to cost–benefit management (Roman, 1981). Through this process, alcohol and drug dependence shifted from a health problem (placement of the EAP in the medical department) to a discipline and cost problem (placement of the EAP in the personnel department). EAPs further shifted from face-to-face, onsite services delivered by a workplace peer- to telephone-based, offsite services delivered by a service professional who had no background working in the industry, no background of personal recovery, nor any preexisting relationship with the employee or the employer (White, 1999).

The early history of occupational alcoholism programs was an exercise in recovery community building; the modern history of employee assistance has been marked by a transition from peer-based assistance within the work setting to professionalized services delivered by individuals outside of the workplace and often outside of the local community. The recent growth in labor assistance programs is, in part, an effort to rebuild those indigenous recovery communities within the workplace (Bacharach, Bamberger, & Sonnenstuhl, 1996; White, 1999). Indigenous, nonprofessionalized recovery support resources emerging out of the life of an institution or community are at risk of being replaced by, or evolving into, services that, as they are professionalized and commercialized, distance themselves physically and culturally from the natural environments of those they serve.

2.5. The Office of Economic Opportunity/Iowa community development model

Today, addiction treatment is delivered as an acute care model of professional intervention that involves a series of encapsulated service activities, that is, screening, assessment, diagnosis, service planning, service delivery, discharge, brief aftercare, and termination of the service relationship. This medicalized approach to AOD problems achieved dominance, but there was a competing model—a road not taken. The alternative model was piloted in several states in the 1960s through the alcoholism programs of the Office of Economic Opportunity (OEO). The OEO model focused on building capacity to address alcohol problems not within a treatment center but within the larger community (White, 1998). These early community-focused alcoholism programs sought to reduce the forces in the community that nurtured the development of AOD problems and to create physical and cultural space within the community where recovery could flourish. The key role within this model was the community alcoholism agent (CAA).

> The CAA functioned as an outreacher, motivator, advisor, empathic friend, confidant, and "follow-upper" providing a long-term continuum of emotional support and common sense advice, all tailored to the individual case. As a catalyst for the larger community process, he is an educator, mobilizer, coordinator and motivator for anyone and everyone he can get involved in the individual's recovery process.…To maximize community involvement, the catalyst does nothing for the alcoholic he can get someone else in the community to do. He acts as a "shoehorn" helping the alcoholic fit himself back into community life through job, family, church, AA, etc., getting as many other people involved in the alcoholic's recovery as possible (Mulford, 1978, pp. 6–7).

The healing agent in this model was the community, not the professional clinician. Those who championed the CAA model charged that the alcoholism field "sold out" in its search for state and federal funds: "To the extent that the centers turned to face the State Capital, they turned their backs on the alcoholics and the communities they had been serving" (Mulford, 1978, p. 11).

The medical and community development models are not mutually exclusive, but this history suggests that, in its search for professional status, an emerging field can shift its emphasis from community mobilization and social and political action to the mastery of clinical technique—a shift not unique to the addiction treatment field (Lubove, 1965; Specht & Courtney, 1994). Interestingly, the CAA model bears a striking similarity to the subsequent development of "social model programs" and "community guides." The social model, as pioneered in California, is an abstinence-based approach to alcoholism recovery that is distinguished by self-governed, homelike living environments; voluntary, peer-based experiential learning (in contrast to professional instruction/intervention); and deep enmeshment in local recovery communities (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998). Community guides are nonprofessional peers who help lead marginalized individuals and families back into healthy, supportive, and contributing relationships within their local communities (McKnight, 1995; Ungar, Manuel, Mealey, Thomas, & Campbell, 2004).

2.6. The RCSP

In 1998, the Center for Substance Abuse Treatment created the Recovery Community Support Program (RCSP). The RCSP provided seed money for grassroots recovery community organizations to launch antistigma campaigns, recovery education programs for professionals and the public, host recovery celebration events, and advocate for prorecovery social policies and programs. The vision was to mobilize recovering people and their families and allies into a positive force in communities across the country, and for the next 3 years, RCSP grantees did exactly that in many communities. RCSP grantees became important building blocks in the rise of the earlier noted new recovery advocacy movement in the United States (White, 2007b).

In 2002, a politically influenced policy shift abruptly ended the advocacy activities allowed under the RCSP, resulting in a shift in focus from advocacy (which was then banned) to peer-based recovery support services. Almost overnight, RCSP grantees shifted from community organizers and political advocates to recovery support specialists.

With the stroke of a pen, a model of recovery community development was transformed into a service mechanism within the acute care model of addiction treatment.

Seen as a whole, the above historical vignettes suggest the power of community to harm and to heal, the role of community in long-term recovery, and the propensity for grassroots models of community development to give way to professional models of clinical intervention. In the remaining discussions, we will explore how this healing power of community could be recaptured to enhance the potency of current intervention models.

3. Treatment, recovery, community: Guiding principles

The role of community in addiction recovery rests on several basic principles.

3.1. AOD problems: Sources and solutions

Individuals with severe AOD problems can be viewed as victims of their own vulnerabilities or as symptoms of system dysfunction—by-products of a breakdown in the relationship between the individual, the family, and the community. Such a breakdown can unfold intergenerationally with terrifying predictability, particularly when imbedded within historical trauma and its legacies (Brave Heart, 2003). Although neurobiological breakthroughs in the understanding of addiction may quiet the morbid physical appetite of addiction, infatuation with new pharmacological adjuncts have the potential of diverting attention from the broader social processes within which both addiction and recovery flourish.

3.2. Cultures of addiction and recovery

The resolution of severe AOD problems is mediated by processes of social and cultural support (Brady, 1995; Laudet, Morgen, & White, 2006; Longabaugh, Beattie, Noel, Stout, & Malloy, 1993; Spicer, 2001). Both general and abstinence-specific social support influence recovery outcomes, but abstinence-specific support is most critical to long-term recovery (Beattie & Longabaugh, 1999; Groh, Jason, Davis, Olson, & Farrari, 2007). The risk of relapse following treatment rises in relationship to the density of heavy drinkers in one's posttreatment social network and declines in tandem with social network support for abstinence (Bond, Kaskutas, & Weisner, 2003; Dennis, Foss, & Scott, 2007; Mohr, Averna, Kenny, & Del Boca, 2001; Weisner et al., 2003). Social support is one of the primary mechanisms of change within recovery mutual aid societies and may be particularly effective in enhancing recovery for individuals imbedded in heavy drinking social networks (Humphreys, Mankowski, Moos, & Finney, 1999; Humphreys & Noke, 1997; Project MATCH Research Group, 1998; Bond et al., 2003). The presence or absence of family and peer support for abstinence is a particularly powerful influence on the recovery outcomes of adolescents treated for a substance use disorder (Godley & Godley, in press).

Many persons with severe and prolonged AOD problems migrate toward heavy AOD using cultures as these problems intensify (Buchanon & Latkin, 2008). Such cultures have been extensively described in the early ethnographic literature on addiction (Agar, 1973; Bahr, 1973; Spradley, 1970; Waldorf, 1973). Elaborate cultures also surround the recovery experience for many individuals. The transition from addiction to recovery is often a journey from one culture to another, each with its own distinct trappings (e.g., language, values, symbols, institutions, roles, relationships, and rituals of daily living; White, 1996). Those with the most enmeshed styles of involvement in a culture of addiction may require an equally enmeshed style of involvement in a culture of recovery to successfully avoid relapse and readdiction. Individuals deeply enmeshed in drug cultures may also need a guide knowledgeable of both cultures to facilitate their disengagement from one world and entrance into the other. Communities vary widely in the degree of development of local cultures of recovery and the availability of such guides. These recovery cultures and cultural guides constitute an invaluable form of *community recovery capital* (White & Cloud, 2008).

3.3. Recovery capital

Recovery capital is the quantity and quality of internal and external assets that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Laudet & White, 2008). Such capital exists in varying degrees for individuals, families, and communities and varies dynamically over time within these units. Individuals with low to moderate AOD problem severity and moderate to high recovery capital often resolve AOD problems on their own through nonprofessional recovery supports within their family or community or through brief professional intervention. This style of problem resolution is well documented in the early research on *spontaneous remission* and *natural recovery* (Biernacki, 1986; Bischof, Rumpf, Hapke, Meyer, & John, 2003; Rumpf, Bischof, Hapke, Meyer, & John, 2002; Tuchfeld, 1981). Individuals with high AOD problem severity and complexity (e.g., co-occurring disorders/problems) and low recovery capital consume an inordinate quantity of treatment resources as they are recycled repeatedly through multiple episodes of acute biopsychosocial stabilization (White, 2008).

3.4. Recovery is a stage-dependent process; treatment is not recovery

Stages through which severe AOD problems are resolved can be broadly defined as (1) destabilization of addiction, (2) recovery initiation and stabilization, and (3) recovery maintenance (Biernacki, 1986; Brown, 1985; De Leon,

1996; Frykholm, 1985; Klingemann, 1991; Prochaska, DiClimente, & Norcross, 1992; Shaffer & Jones, 1989; Waldorf, 1983; Waldorf, Reinarman, & Murphy, 1991). Although Stages 1 and 2 can occur in an artificial environment (e.g., via incarceration or hospitalization), Stage 3 can only be fully achieved within a natural environment in the community.

Brief episodes of crisis-induced abstinence, biopsychological stabilization, and the resulting flush of health and great intentions do not constitute sustainable recovery and are as likely to be milestones in one's addiction career as a portal of entry into long-term recovery (Scott, Foss, & Dennis, 2005; Venner, Tonigan, & Feldstein, 2005; White, 2007a).

What is required to sustain recovery is qualitatively different than what is required to initiate recovery (Humphreys, Moos, & Finney, 1995). The acute care model of addiction treatment provides an opportunity for recovery initiation but may or may not exert an influence on the process of recovery maintenance. A growing number of "system-sophisticated" clients have acquired skills in recovery initiation (e.g., "doing treatment") but repeatedly relapse due to their failure to make the transition to recovery maintenance in natural, noninstitutional environments. What is needed in such circumstances is not an unending series of treatment episodes (more recovery initiation), but a focus on building the personal, family, and community recovery capital required for long-term recovery maintenance. That process requires interventions at the individual, family, and community levels (White, 2008).

3.5. Catalytic metaphors

Certain words and ideas can, through the power of their cognitive, emotional, and spiritual salience, spark a reconstruction in personal character, identity, interpersonal relationships, and life purpose, and through that process, ignite and sustain the process of addiction recovery (Miller & C'de Baca, 2001). For individuals seeking recovery, such an idea "explains many things for which we cannot otherwise account" (AA, 1939, p. 2). Such metaphors are the building blocks of the story reconstruction and storytelling processes that are a near universal aspect of the recovery process and differ markedly across individuals and cultural groups (White, 1996). Communities can widen the doorways of entry into recovery by expanding the diversity of addiction/recovery metaphors available to its citizens. Treatment institutions can enhance personal/family recovery by assuring that the sense-making metaphors utilized in the service process are culturally transferable to each client's/family's natural environment.

3.6. Physical/Psychological/Cultural distance

The greater the physical, psychological, and cultural distance between a treatment institution and the natural environments of its clients, the greater is the problem of transfer of learning from the institutional to the natural environment (White, 2002). Community reintegration is enhanced by service organizations whose facilities resemble the surrounding community and the expected posttreatment environments of their clients and who promote client access to prosocial, prorecovery activities in these environments (Makas, 1993). Repeatedly readmitting an adolescent into inpatient addiction treatment (who quickly relapses when discharged into his or her drug-saturated social environment) without shaping the posttreatment environment and supporting recovery within this environment is a form of institutional profiteering, in effect if not intent.

The chasm between institutional and natural environments can be lessened by extending the service process into the daily life of the community and by inviting the community into the daily life of the service institution. One of the factors contributing to the exceptionally high addiction recovery rates within Physician Health Programs is anchoring recovery within the natural environment of each physician via years of posttreatment monitoring, support, and when required, early reintervention (White, DuPont, & Skipper, 2007).

3.7. Community as an active recovery ingredient

The community is not an inert stage on which the trajectories of addiction and recovery are played out. The community is the soil in which such problems grow or fail to grow and in which the resolutions to such problems thrive or fail to thrive over time. That soil contains promoting and inhibiting forces for both addiction recovery. The ratio of such forces can tip the scales of recovery initiation efforts toward success or failure (Sung & Richter, 2006). As such, the community itself should be a target of intervention into AOD problems. At present, claims of cultural ownership of AOD problems is split into ideological camps, including a public health model that focuses on environmental strategies for the management of AOD problems and a clinical model that focuses on the professional treatment of individuals experiencing such problems. There is considerable potential in the integration of these two approaches.

3.8. The contagiousness of recovery

Metaphors of contagion (e.g., *epidemic*, *plague*, *outbreak*) have long been used to describe the rapid social transmission of AOD problems within local communities—particularly during periods of drug panic (Jenikins, 1994). Recovery is also contagious—is socially transmitted—and can help stem surges in AOD use. A viable goal of AOD-related community intervention strategies is, in the absence of effective prevention, to shorten addiction careers and extend recovery careers. This requires effective strategies of sustained recovery management and service opportunities that turn people who were once addiction carriers into carriers of recovery.

3.9. Potential iatrogenesis of professional intervention

Where professional institutions and services have been overdeveloped (e.g., have taken over the natural support functions of families, extended families, and indigenous helping institutions), they may inadvertently erode natural support structures and, in so doing, inflict long-term injury on the community (McKnight, 1995). Professional resources should never be used to meet a need that can be met within community relationships that are natural, enduring, reciprocal, and noncommercialized. The goal of professional intervention, based on the ethical values of autonomy and stewardship, is ideally the mobilization of both personal/family resources and community resources to minimize the need for professional assistance. Treatment is best thought of as an adjunct of the community rather than the community being viewed as an adjunct of treatment.

3.10. Communities of recovery

Spiritual, religious, and secular communities of recovery, including rapidly growing online recovery support communities, are increasing in number, diversity, and geographical dispersion in the United States, as are recovery support groups for special populations and needs (Humphreys, 2004; Kurtz & White, 2007; White & Kurtz, 2006a). Yet most of what we know as a professional field about recovery mutual aid is based on studies of AA. Early research on AA lacked methodological rigor (Emrick, Tonigan, Montgomery, & Little, 1993; Kownascki & Shadish, 1999), but the quality of AA studies has improved markedly in the past decade (Humphreys, 2006). The diversity that exists within and across mutual aid societies has yet to be adequately captured in the scientific literature or within the knowledge base of the field's service practitioners (Humphreys, 2004; Kelly & Yeterian, 2008). Other than the possible exception of Narcotics Anonymous, few adaptations of AA's Twelve Step program have been rigorously studied, and only a small body of descriptive literature exists on secular and explicitly religious addiction recovery mutual support societies. The challenges in mobilizing the resources of these communities to aid persons entering and leaving addiction treatment include recognizing the legitimacy of these diverse groups, fully integrating a philosophy of choice related to each client's use of these resources, and training staff to be knowledgeable of each group's core ideas, language, behavioral prescriptions, service structures, and meeting rituals (White & Kurtz, 2006a).

3.11. Recovery community building

There are many clients for whom family and community are more a source of sabotage than support for recovery (Falkin & Straus, 2003). The only solutions intrapersonal models of treatment have to this dilemma are to further bolster the individual's resistance or receptiveness to such forces or challenge the client to change his or her environment. An alternative is to change the family/community recovery environment through three community-level interventions: (a) extending the reach of professionally directed treatment services into the community, (b) integrating community resources into treatment institutions and the treatment experience, and (c) increasing the role of addiction treatment institutions in recovery advocacy and recovery community building efforts.

4. The power of community: a discussion of strategies

There are three essential treatment-related strategies to enhance the healing power of community in the long-term recovery process: outreach, inreach, and recovery community building. These broad strategies involve:

- identifying, engaging, and extracting individuals from existing cultures of addiction at the earliest possible stages of problem development or redevelopment (Abdul-Quaderm, Des Jarlais, McCoy, Morales, & Velez, 2003; Coviello, Zanis, Wesnoski, & Alterman, 2006);
- suppressing the physical, economic, and cultural conditions within which cultures of addiction flourish (Williams & Laird, 1992);
- cultivating alternative cultures of recovery and enhancing their growth and vibrancy (White, 1996);
- assertively matching and linking individuals and families to one or more cultures of recovery (White & Kurtz, 2006a); and
- providing sustained posttreatment monitoring and support (Cacciola et al., 2008; Dennis, Scott, & Funk, 2003).

4.1. Outreach

Outreach as defined here is the extension of professional addiction treatment services into the life of the community, including supporting clients within their natural environments following the completion of primary treatment. Through the outreach process, addiction professionals and their representatives (including alumni and volunteers) extend core treatment and recovery support services beyond institutional walls to support individuals estranged from prorecovery supports within the community. These services potentially span the prerecovery, recovery initiation, recovery stabilization, and recovery maintenance stages. Examples of such strategies include the following:

- Directing or participating in recovery-focused community and professional education programs, for example, www.recoveryiseverywhere.com.
- Developing intervention models for the full range of AOD problems, including mild to moderate problems

that may be amenable to resolution strategies other than abstinence-based treatment (McLellan, 2007).
- Promoting screening and brief interventions (high bottom outreach) via primary physicians, hospital emergency rooms, health clinics, and health fairs aimed at early problem identification and resolution (Bien, Miller, & Tonigan, 1993).
- Transcending the dichotomies between harm reduction and abstinence-based treatment and clinical and mutual-aid approaches by developing integrated, staged responses that span the tenure of addiction and recovery careers (Kellogg, 2003; White & Kurtz, 2006a).
- Conducting assertive street and institutional engagement (e.g., crisis centers, jails, homeless shelters, hospitals; low bottom outreach; "recovery priming") that capitalizes on developmental windows of opportunity within addiction careers to identify, engage, and retain those with AOD problems.
- Improving access via streamlined intake, induction services for those on waiting lists, barrier removal (e.g., for persons with disabilities), and ancillary support services such as transportation and daycare.
- Enhancing retention via institutional outreach, for example, a recovery coach whose job is to regularly monitor, reengage, and remotivate.
- Elevating the visibility of local recovery role models in collaboration with local recovery community organizations and recovery ministries.
- Providing service prompts via face-to-face, telephone-based, internet-based, and/or postal contact before all service appointments and rapid contact following any and all missed appointments.
- Delivering services in natural, nonstigmatized sites, for example, use of satellite clinics, colocation of treatment services within other service settings, for example, schools, workplaces, churches, health clinics, neighborhood centers.
- Increasing home-based service delivery, for example, delivering primary treatment services via home visits and via the telephone and internet.
- Maintaining assertive contact with and involving each client's family and kinship network members in the treatment and posttreatment recovery support process.
- Enhancing staff knowledge of local communities of recovery via expectation that all direct service staff will attend open meetings of local and online recovery support groups at least monthly.
- Developing an assertive approach to continuing care, for example, posttreatment monitoring and support, stage-appropriate recovery education, and, when needed, early reintervention (Dennis et al., 2003).
- Delivering posttreatment recovery support services in homes, workplaces, schools, and other natural environments (Foote & Erfurt, 1991).

There is a style of assertiveness reflected in the above prescriptions that contrasts with what has often been a "take it or leave it" attitude of addiction treatment programs toward their clients. This style difference is best illustrated by comparing traditional approaches to "aftercare" to this more assertive style of continuing care. The clinically relevant differences between passive models of "aftercare" and assertive approaches to sustained recovery management are illustrated in Table 2 (adapted from White & Kurtz, 2006a).

The technologies used to conduct longitudinal studies of addiction treatment are now capable of generating exceptionally high follow-up rates for 5 years and longer (Scott & Dennis, 2000). These technologies could be adapted and refined for posttreatment monitoring, support, and early reintervention. Preliminary reports on such "recovery checkups" suggest great promise in elevating long-term recovery outcomes for adults (Dennis et al., 2003) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002). Posttreatment monitoring can be done in a telephone-

Table 2
Traditional aftercare versus assertive recovery management

Dimension	Traditional aftercare	Assertive recovery management
Who receives it	Only clients who "graduate"	All clients admitted for services including those in detox and those leaving against staff advice or administratively discharged
Responsibility for contact	The client	The service provider
Timing and duration of contact	Set schedule, e.g., weekly aftercare group	Saturation of support in first 90 days following primary treatment using multiple media; individualized schedule of sustained recovery checkups for up to 5 years. Client helps define contact schedule
Choice related to recovery support	Recovery pathway dictated by service professional	Client oriented to multiple recovery support strategies and structures; client chooses
Linkage to communities of recovery	Verbal encouragement to attend and get a sponsor	Matching of client to particular support group representative or meeting with monitoring of response
Media	F-2-f individual or group meetings	Multiple media: f-2-f, telephone, internet, mail
Where	Contact in institutional settings	Contact in natural settings whenever possible
Staff response to report of a client's relapse	Sadness and regret	Immediate reengagement via staff-initiated contact
Response at readmission	Shaming and repetition of past treatment protocol	Welcoming: affirmation of reengagement decision; formulation of an immediate and long-term recovery plan

Note. f-2-f = face-to-face.

based format that is both clinically and cost-effective (Cacciola et al., 2008; McKay, 2005; McKay, Lynch, Shepard, & Pettinati, 2005). The potential of the internet for such posttreatment support has yet to be fully explored, although some programs (e.g., Hazelden) are experimenting with the use of such technology, and there is a growing body of literature on internet-based screening for alcohol and drug problems (Kypri et al., 2004; Saitz et al., 2004), online recovery support groups (Hall & Tidwell, 2003; Humphreys & Klaw, 2001), and E-counseling (Copeland & Martin, 2004; Griffiths, 2005).

The chaotic lifestyles of the addicted once constituted the rationale for low follow-up rates in treatment outcome studies. Such a rationale is no more acceptable today in the clinical setting than it is in the research setting. The technology exists to maintain indefinite, supportive contact with clients discharged from addiction treatment. What is needed is the professional will, the research-based monitoring protocols, and the funding mechanisms to do it.

4.2. Inreach

Inreach is the inclusion of indigenous community resources within professionally directed addiction treatment. Potential inreach strategies include the following:

- Engaging family and social network members in the recovery support process (Galanter et al., 2002).
- Developing vibrant Consumer Councils and Alumni Associations.
- Providing recovery mentoring to each client via a formal volunteer program that includes alumni association and consumer council members.
- Formalizing relationships with religious, spiritual, and secular recovery mutual aid groups, for example, regular meetings with Hospital and Institution Committees and other service structure representatives (White & Kurtz, 2006a).
- Encouraging the development of, and formalizing relationships with, local recovery community organizations, recovery support centers, and recovery community institutions, for example, recovery homes, recovery schools, and so forth (Valentine et al., 2007).
- Increasing recovery community representation and diversity of such representation at all levels of the treatment organization, for example, board, staff, volunteer, advisory committee representation.
- Inviting recovery community representatives to educate staff and clients on the varieties of recovery experience.
- Promoting a "choice philosophy" that acknowledges the legitimacy of multiple pathways and styles of long-term recovery (White & Kurtz, 2006b).
- Using recovery-focused assessment instruments and protocols that evaluate the personal, family, and community recovery capital of each client.
- Including indigenous healers within multidisciplinary treatment and recovery support teams.
- Including primary care physicians in primary treatment and as a mechanism for long-term, health-focused recovery checkups.
- Contracting with recovery community organizations to provide recovery coaching to clients discharged from addiction treatment.

Outreach and inreach are ways to increase boundary transactions between treatment institutions, local communities of recovery, and the larger community. By reversing the status of addiction treatment institutions as closed systems, the community has greater access to the resources of the treatment institution, and the treatment institution and its clients have greater access to and a greater ability to influence long-term sources of recovery support that reside within the community.

4.3. Recovery community building

Recovery community building includes activities that nurture the development of cultural institutions in which persons recovering from severe AOD problems can find relationships that are recovery supportive, natural (reciprocal), and potentially enduring. Although recovery community building can be described in clinical metaphors (e.g., "the community as the client" or "treating the community"), community building represents knowledge and skills not drawn from clinical disciplines. Where addiction treatment has drawn heavily from the disciplines of psychiatry, psychology, and social work; recovery community building draws upon knowledge drawn from public health, sociology, social movements, community development, and community organization. One way to help make this shift in orientation is to think of treatment as a tool to help prepare individuals and families for the recovery process and to think of community building as a way to create a world in which that recovery can occur, be enriched, and be sustained over an indefinite period.

The changing status of African Americans, women, and sexual minorities in the United States over the past half century was accomplished first by a change in social consciousness within these respective groups and then by prolonged community building activities. Community building is the process through which historically colonized and marginalized groups redefine themselves, assert themselves, and elevate personal, family, and community health. The cultural development spawned by the civil rights movement, the women's movement, and the lesbian, gay, bisexual, and transgender/transsexual rights movement spawned charismatic leaders, new values, a new lexicon, musical anthems, celebratory art, new cinematic themes and heroes, a retrieval of lost history and culture, new literary genres, and new catalytic symbols, and stories. However, these movements also had physical places—

buildings and neighborhoods—that represented sanctuaries of personal and cultural transformation.

Is it not time such physical and cultural centers for recovery existed that transcend the iconic institutions of a particular recovery fellowship (e.g., Dr. Bob's Home or Stepping Stones)? Is it not time drug-saturated neighborhoods were transformed into a neighborhood in recovery? When recovery advocates walk through dope-copping neighborhoods cleaning up drug paraphernalia and other refuse, they sow seeds of hope that clean up more than the streets. When shooting galleries, crack houses, and after-hours joints are squeezed out by recovery homes, recovery support centers, and recovery infused neighborhoods, the community as well as individuals and families enter a process of recovery.

Community building will require the creation of new social institutions, for example, recovery community organizations (Valentine et al., 2007), and new service roles, for example, recovery coaches (White, 2006a) that collectively provide physical, psychological, social, cultural, and spiritual sustenance to people in recovery at the same time they advocate for changes in the larger society that benefit those seeking or in recovery. The new addiction recovery advocacy movement represents a form of community building, and the recovery homes, recovery schools, recovery industries, and recovery churches/ministries represent new social institutions through which diverse communities of recovery are acting in concert.

The development of these institutions, particularly those involving housing, encounter initial "not in my backyard" resistance from the wider community, but such resistance can often be overcome with careful planning, community education, neighborhood-level relationship building, and legal challenges to discriminatory zoning regulations/enforcement. An example of such success is the Oxford House network of more than 1,200 recovery homes in 48 states. These homes, which houses more than 24,000 recovering people per year, have been rigorously evaluated and found to play a significant role in enhancing long-term recovery outcomes (Jason et al., 2001; Jason, Olson, Ferrari, & Lo Sasso, 2006). Studies of Oxford House and other supportive housing programs have also concluded that (a) most neighbors in the surrounding community are unaware of the existence of the recovery home, (b) those neighbors who live closest to these homes have the most positive attitudes toward them, (c) there is no effect on crime rates in the surrounding area when a recovery home opens, and (d) property values are unaffected or actually increase in close proximity to such homes (Aamodt & Chiglinsky, 1989; Galaster, Tatian, & Pettit, 2004; Jason, Roberts, & Olson, 2005). Neighborhoods and communities draw added value from recovery institutions via increased knowledge about addiction recovery and acceptance of recovering people and through the neighborhood/community service activities rendered by recovering people (Jason et al., 2005; Kurtz & Fisher, 2003).

Personal recovery flourishes in communities that create the physical, psychological, and cultural space for recovery to grow and sustain itself. Local communities of recovery and their related social institutions constitute agents of healing in their own right that can serve as both adjuncts and, in some cases, alternatives to professionally directed addiction treatment. Treatment institutions can play supportive roles in such recovery community building by:

- Confronting AOD promotional forces in the community, for example, confronting AOD-related marketing that targets vulnerable populations, actively resisting saturation of AOD outlets in communities of color, challenging lax enforcement of AOD laws, creating local bans on AOD promotions such as Ladies Night and happy hour promotions, supporting tax increases on alcohol and tobacco products.
- Collaborating with recovery community organizations to prepare and release an annual community "recovery report card" with data on key recovery benchmark measures.
- Encouraging the development of alternative recovery support groups, specialty meetings, and related structures (e.g., clubhouses; Mallams, Godley, Hall, & Meyers, 1982).
- Forging partnership (nonpaternal, nonmanipulative) relationships with local recovery community organizations.
- Promoting prorecovery policies at national, state, and local levels.
- Promoting the development of a full continuum of treatment and recovery support services, including services not related to the financial interests of the treatment institution.
- Providing training and technical assistance to enhance the quality and diversity of local recovery support services.
- Financially contributing to and participating in recovery celebration events.
- Developing special community reentry supports for those persons seeking recovery following prolonged institutionalization (e.g., Winner's Community).
- Cultivating mechanisms of community reintegration and citizenship, for example, prorecovery social activities and opportunities for community service.
- Providing guides that can lead individuals into relationships with one or more communities of recovery and into activities within the larger community that are conducive to long-term recovery.
- Providing outlets for artistic expression of recovery community members through music, art, theater, literature, and comedy.
- Challenging regulatory policies that lead to the depersonalization of addiction treatment.

In the end, it is the community, not the treatment center, that can offer those with addiction histories invitation for

social inclusion. The treatment center can play a crucial role in shaping a community environment in which people in recovery are welcomed and where recovery can flourish. Tipping the scales of readdiction or recovery may hinge as much on that environment as the unique assets and vulnerabilities of each client.

5. A closing reflection

Addiction treatment institutions that in their founding missions defined themselves as community-based service organizations are today more likely to define themselves as businesses. It is time treatment organizations rebuilt the connecting tissue between themselves and the communities they serve. It is time treatment institutions rediscovered the natural healing powers that lie within the communities in which their clients are nested. When universities became too isolated from the communities they once served, there were calls for these institutions to move back into the life of their communities—to become "universities without walls." It is time we as a professional field begin to think of treatment and recovery without walls (White, 2002). If we achieve that, we will by necessity erase the boundaries that have artificially separated primary prevention, early intervention, treatment, and recovery.

Acknowledgments

This article was prepared for the Second Betty Ford Institute Consensus Conference: Extending the Benefits of Addiction Treatment: Practical Strategies for Continuing Care and Recovery, October 3–4, Rancho Mirage, CA. I wish to acknowledge an anonymous reviewer for many helpful suggestions to improve this article.

References

Aamodt, M. G., & Chiglinsky, M. (1989). A meta-analytic review of the effects of residential homes on neighborhood property values and crime rates. *Journal of Police and Criminal Psychology*, *5*, 20−24.

Abdul-Quaderm, A. S., Des Jarlais, D. C., McCoy, E., Morales, G., & Velez, I. (2003). Outreach to injecting drug users and female sexual partners of drug users on the Lower East Side of New York City. *Addiction*, *22*, 681−688.

Agar, M. (1973). *Ripping and running: A formal ethnography or urban heroin addicts*. New York: Seminar Press.

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

Alcoholics Anonymous. (1981). *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services, Inc.

Bacharach, S. B., Bamberger, P. A., & Sonnenstuhl, W. J. (1996). MAPs: Labor-based peer assistance in the workplace. *Industrial Relations*, *35*, 261−275.

Bahr, H. (1973). *Skid row: An introduction to disaffiliation*. New York: Oxford University Press.

Beattie, M. C., & Longabaugh, R. (1999). General and alcohol-specific social support following treatment. *Addictive Behaviors*, *24*, 593−606.

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.

Bien, T., Miller, W., & Tonigan, J. (1993). Brief intervention for alcohol problems: A review. *Addiction*, *88*, 315−336.

Biernacki, P. (1986). *Pathways from heroin addiction: Recovery without treatment*. Philadelphia: Temple University Press.

Bischof, G., Rumpf, F. J., Hapke, U., Meyer, C., & John, U. (2003). Types of natural recovery from alcohol dependence: A cluster analytic approach. *Addiction*, *98*, 1737−1746.

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

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

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*, 7−17.

Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science Medicine*, *41*, 1487−1498.

Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, *35*, 7−13.

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery*. New York: Wiley.

Brown, S., & Lewis, B. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

Buchanon, A. S., & Latkin, C. A. (2008). Drug use in the social networks of heroin and cocaine users before and after drug cessation. *Drug and Alcohol Dependence*, *96*, 286−289.

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.

Clark, W. (2007). Recovery as an organizing concept. Accessed June 26, 2007 at http://www.glattc.org/Interview%20With%20H.%20Westley%20Clark,%20MD,%20JD,%20MPH,%20CAS,%20FASAM.pdf.

Copeland, J., & Martin, G. (2004). Web-based interventions for substance use disorders: A qualitative review. *Journal of Substance Abuse Treatment*, *26*, 109−116.

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.

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

Davidson, L., & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *Journal of Behavioral Health Services and Research*, *34*, 1094−3412.

De Leon, G. (1996). Integrative recovery: A stage paradigm. *Substance Abuse*, *17*, 51−63.

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*, 585−612.

Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*, 45−55.

Dennis, M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning*, *26*, 339−352.

Department of Health and Human Services (DHHS). (2003). *Achieving the promise: Transforming mental health care in America*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Else, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery*, *6*, 11−23.

Emrick, D. C., 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.

Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Accessed June 26, 2007 at http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf.

Falkin, G. P., & Straus, S. M. (2003). Social supporters and drug use enablers: A dilemma for women in recovery. *Addictive Behaviors*, *28*, 141−155.

Foote, A., & Erfurt, J. C. (1991). Effects of EAP follow-up on prevention of relapse among substance abuse clients. *Journal of Studies on Alcohol*, *52*, 241−248.

Frykholm, B. (1985). The drug career. *Journal of Drug Issues*, *15*, 333−346.

Gagne, C. A., White, W., & Anthony, W. A. (2007). Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal*, *32*, 32−37.

Galanter, M., Dermatis, H., Keller, D., & Trujillo, M. (2002). Network therapy for cocaine abuse: Use of family and peer supports. *American Journal of Addiction*, *11*, 161−166.

Galaster, G., Tatian, P., & Pettit, K. (2004). Supportive housing and neighborhood property value externalities. *Land Economics*, *80*, 33−53.

Godley, M., Godley, S., Dennis, M., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21−32.

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, NJ: Civic Research Institute.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Griffiths, M. (2005). Online therapy for addictive behaviors. *Cyberpsychology and Behavior*, *8*, 555−561.

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. *American Journal on Addictions*, *16*, 49−55.

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*, 161−167.

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

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

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*, 528−532.

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*, 54−60.

Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*, *20*, 427−441.

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*, 1−16.

Institute of Medicine (IOM). (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, DC: The National Academies Press.

Janzen, R. (2001). *The rise and fall of Synanon*. Baltimore: Johns Hopkins University Press.

Jason, L. A., Davis, M. I., Ferrari, J. R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, *31*, 1−27.

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.

Jason, L. A., Roberts, K., & Olson, B. D. (2005). Attitudes toward recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology*, *33*, 529−535.

Jenikins, P. (1994). “The ice age” the social construction of a drug panic. *Justice Quarterly*, *11*, 7−31.

Kellogg, S. H. (2003). On “Gradualism” and the building of the harm reduction–abstinence continuum. *Journal of Substance Abuse Treatment*, *25*, 241−247.

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.

Kirk, T. (2007). Creating a recovery-oriented system of care. Accessed June 26, 2007 at http://www.glattc.org/Interview%20With%20Thomas%20A.%20Kirk,%20Jr.,%20PhD.pdf.

Klingemann, H. K. H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of the Addictions*, *86*, 727−744.

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*, 1897−1916.

Kurtz, E. (1979). *Not—God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden.

Kurtz, E., & White, W. (2007). *Telephone- and internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Kurtz, L., & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems*, *30*, 875−904.

Kypri, K., Saunders, J. B., Williams, S. M., McGee, R. O., Langley, J. D., Cashell-Smith, M. L., et al. (2004). Web-based screening and brief intervention for hazardous drinking: A double-blind randomized controlled trial. *Addiction*, *99*, 1410−1417.

Laudet, A., Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, *24*, 33−73.

Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*, *43*, 27−54.

Longabaugh, R., Beattie, M. C., Noel, N., Stout, R., & Malloy, P. (1993). The effect of social investment on treatment outcome. *Journal of Studies on Alcohol*, *54*, 465−478.

Lubove, R. (1965). *The professional altruist: The emergence of social work as a career, 1880–1930*. Cambridge, MA: Harvard University Press.

Makas, E. (1993). Getting in touch: The relationship between contact with and attitudes toward people with disabilities. In M. Nagle (Ed.), *Perspectives on disability* (pp. 121−136). Palo Alto, CA: Health Market Research.

Mallams, J. H., Godley, M. D., Hall, G. M., & Meyers, R. J. (1982). A social-systems approach to resocializing alcoholics in the community. *Journal of Studies in Alcohol*, *43*, 1115−1123.

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*, 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*, 199−207.

McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books.

McLellan, A. T. (2007). Reducing heavy drinking: A public health strategy and a treatment goal. *Journal of Substance Abuse Treatment*, *33*, 81−83.

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*, 1689−1695.

Miller, W. R., & C'de Baca, J. (2001). *Quantum change*. New York: Guilford.

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*, 637−645.

Morgan, O. J. (1995). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly*, *12*, 59−71.

Mulford, H. (1978, Septemberr). Accelerating the natural alcoholic recovery process. Presented at the 32nd International Congress on Alcoholism and Drug Dependence, Warsaw, Poland.

Musto, D. (1973). *The American disease: Origins of narcotic controls*. New Haven: Yale University Press.

O ' Brien, C. P., & McLellan, A. T. (1996). Myths about the treatment of addiction. *Lancet*, *347*, 237−240.

Prochaska, J., DiClimente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*, 1102−1114.

Project MATCH Research Group. (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical & Experimental Research*, *22*, 1300−1311.

Roman, P. (1981). From employee alcoholism to employee assistance: An analysis on the de-emphasis of prevention and alcoholism in work-based programs. *Journal of Studies on Alcohol*, *42*, 244−272.

Rumpf, H., Bischof, G., Hapke, U., Meyer, C. Y., & John, U. (2002). The role of family and partnership in recovery from alcohol dependence: Comparison of individuals remitting with and without formal help. *European Addiction Research*, *8*, 122−127.

Saitz, R., Helmuth, E. D., Aromaa, S. E., Guard, A., Belanger, M., & Rosenbloom, D. L. (2004). Web-based screening and brief intervention for the spectrum of alcohol problems. *Preventive Medicine*, *39*, 969−975.

Schmitt, M. M. (2003). *Recovery from substance abuse: The role of unsupportive social interactions [dissertation]*. Richmond, Virginia: Virginia Commonwealth University.

Scott, C. K., & Dennis, M. L. (2000). A cost-effective approach to achieving over 90% follow-up in outcome monitoring with substance abuse treatment clients. *Drug and Alcohol Dependence*, *60*(Suppl 1), s200.

Scott, C. K., Foss, M. A., & Dennis, M. L. (2005). Pathways in the relapse–treatment–recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, *28*(Suppl 1), S63−S72.

Shaffer, H. J., & Jones, S. B. (1989). *Quitting cocaine: The struggle against impulse*. Lexington, MA: Lexington Books.

Specht, H., & Courtney, M. (1994). *Unfaithful angels: How social work has failed its mission*. New York: The Free Press.

Spicer, P. (2001). Culture and the restoration of self among former American Indian drinkers. *Social Science & Medicine*, *53*, 227−240.

Spradley, J. (1970). *You owe yourself a drunk: An ethnography of urban nomads*. Boston: Little, Brown and Company.

Sung, F., & Richter, L. (2006). Contextual barriers to successful reentry of recovering drug offenders. *Journal of Substance Abuse Treatment*, *31*, 365−374.

Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Use Treatment*, *25*, 245−253.

Taylor, V. (1987, Falll). The triumph of the Alkali Lake Indian band. *Alcohol Health and Research World*, 57.

The Red Road to Wellbriety. Colorado Springs, CO: White Bison, Inc.

Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol*, *42*, 626−641.

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*, 550−561.

Valentine, P., White, W., & Taylor, P. (2007). The recovery community organization: Toward a definition. Accessed September 10, 2008 at: http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf.

Venner, K. L., Tonigan, J. S., & Feldstein, S. W. (2005). Abstinence versus sobriety: A retrospective study of drinker and non-drinker well-being. *Alcoholism: Clinical and Experimental Research*, *29*, 33A (Abstract).

Waldorf, D. (1973). *Careers in dope*. Englewood Cliffs, NJ: Prentice Hall.

Waldorf, D. (1983). Natural recovery from opiate addiction: Some social–psychological processes of untreated recovery. *Journal of Drug Issues*, *13*, 237−280.

Waldorf, D., Reinarman, C., & Murphy, S. (1991). *Cocaine changes: The experience of using and quitting*. Philadelphia, PA: Temple University.

Weisner, C., Matzger, H., & Kaskutas, L. A. (2003). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. *Addiction*, *98*, 901−911.

Westermeyer, J. (1989). Nontreatment factors affecting treatment outcome in substance abuse. *American Journal of Drug and Alcohol Abuse*, *15*, 13−29.

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

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

White, W. (1999). Listening to history: Lessons for the EAP/Managed Care field. *EAP Digest*, *20*, 16−26.

White, W. (2001). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly*, *19*, 1−21.

White, W. (2002). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly*, *19*, 1−32.

White, W. (2004). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction*, *99*, 532−538.

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*, 3−15.

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

White, W. (2006b). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity*. Philadelphia, PA: Philadelphia Department of Behavioral Health.

White, W. (2007a). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229−241.

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

White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

White, W., Boyle, M., & Loveland, D. (2002). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, *20*, 107−130.

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

White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, *7*, 54−58.

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

White, W., & Kurtz, E. (2006b). The varieties of recovery experience. *International Journal of Self Help and Self Care*, *3*, 21−61.

White, W. L., DuPont, R. L., & Skipper, G. E. (2007). Physicians health programs: What counselors can learn from these remarkable programs. *Counselor*, *8*, 42−47.

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