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## **Recovery: Old Wine, Flavor of the Month or New Organizing Paradigm?**

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### **Abstract**

*Recovery is emerging as an influential but ill-defined organizing concept for addiction treatment<sup>1</sup> and the larger field of behavioral health care. The reification of the concept of recovery is discounted by some as nothing new ("We're already recovery oriented."), an ephemeral fad lacking substance and import ("This is old wine in a new wineskin."), or as hopelessly impractical ("Nobody will pay for it."). This essay uses historical analysis and treatment system performance data to argue that recovery is a revolutionary concept. Policymakers who are embracing this concept via the vision of a recovery-oriented systems of care are, in spite of innumerable obstacles, radically altering the present design of addiction treatment.*

El restablecimiento surge como concepto de organización influyente pero mal definido para el tratamiento de inclinación y campo mayor de salud comportamental. El reificación del concepto del restablecimiento se espera por algunos como nada de nuevo ("somos ya restablecimiento orientado"), una manía transitoria careciendo de sustancia e importación ("es viejo vino en un nuevo wineskin."), o como desesperadamente impracticable ("nadie lo pagará lo."). Esta prueba emplea datos históricos de ejecución de análisis y sistema de tratamiento para alegar debido a que el restablecimiento es un concepto revolucionario. Los decisores que abarcan este concepto por medio de la visión de los sistemas restablecimiento- orientados de cuidado, a pesar de obstáculos innumerables, cambian radicalmente la concepción actual del tratamiento de inclinación.

Le rétablissement émerge comme concept d'organisation influent mais mal défini pour le traitement de penchant et champ plus grand de santé comportementale. Le reification du concept du rétablissement est escompté par certains en tant que rien de neuf ("nous sommes déjà rétablissement orienté"), une manie éphémère

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<sup>1</sup> Treatment can be briefly and usefully defined as a planned, goal directed change process, which is *bounded* (culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help based ( AA,NA, etc.) and self-help ("natural recovery") models. There are no unique models or techniques used with substance users- of whatever types- which aren't also used with non-substance users. In the West, with the relatively new ideology of "harm reduction" and the even newer Quality of Life (QOL) treatment-driven model there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence driven models. Non-clinical support and help is part of a broad range of mutual aid process which is not unique to the substance use(r) intervention arena. Editor's note.

manquant de la substance et importation ("c'est vieux vin dans un nouveau wineskin."), ou comme désespérément impraticable ("personne ne payera lui."). Cet essai emploie des données historiques d'exécution d'analyse et de système de traitement pour arguer du fait que le rétablissement est un concept révolutionnaire. Les décideurs qui embrassent ce concept par l'intermédiaire de la vision de l'es systèmes rétablissement-orientés du soin, malgré des obstacles innombrables, changent radicalement la conception actuelle du traitement de penchant.

**KEY WORDS** for Indexing: recovery, recovery capital, sustained recovery, recovery mutual aid, recovery management, chronic disease model

## **Introduction**

In the alcohol and other drug use-related problems arena, *recovery* has moved from a culturally hidden and highly personal lived experience to a conceptual fulcrum of change for addiction-related social and political policies and the clinical design of addiction treatment (White, 2005a). The recovery mantra seems to be everywhere. Addiction recovery mutual aid groups have grown internationally and now span religious, spiritual, and secular frameworks of recovery (Humphreys, 2004; White, 2004a). Recovering people and their families have joined with visionary professionals to rebirth grassroots addiction recovery advocacy organizations and link these local organizations into an increasingly visible national movement (White, 2006a; [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org)). Recovery-focused public education campaigns (e.g., Recovery Month, [www.recoveryiseverywhere.com](http://www.recoveryiseverywhere.com)) and recovery celebration events (e.g., marches and festivals) are rapidly increasing. This advocacy movement has spawned a related movement to expand non-clinical recovery support roles (e.g., outreach workers, recovery coaches, recovery support specialists) (White, 2006b) and recovery support service institutions (e.g., recovery community organizations, recovery homes, recovery schools, recovery-based industries, recovery churches) (Jason, Davis, Ferrari, & Bishop, 2001; White & Finch, 2006).

In the professional treatment arena, there have been sustained calls to reconnect treatment to the larger and more enduring process of addiction recovery (Morgan, 1995; Else, 1999; White, 2004b) by shifting addiction treatment from a strictly acute care model of intervention to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002; Dennis & Scott, in press). Calls have also been made to use recovery as a conceptual bridge in the integration of the addiction treatment and mental health fields (White, Boyle, & Loveland, 2004; Davidson & White, in press; Anthony, Gagne, & White, in press).

At the policy level, there is clear evidence of recovery-focused shifts in national behavioral health care policy (DHHS, 2003; Institute of Medicine, 2006). These shifts have moved beyond a new rhetoric to serious attempts to elevate recovery and the role of recovering people and their families within federally-sponsored activities, e.g., the Center for Substance Abuse Treatment's (CSAT) Recovery Summit and other recovery-themed conferences as well as new service initiatives such as CSAT's Recovery Community Support Program (RCSP)<sup>2</sup> and

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<sup>2</sup> The Recovery Community Support Program is a grant program initiated by the Center for Substance Abuse Treatment in 1998. Its early focus was on funding more than 30 local community organizations across the United States to mobilize communities of recovery, advocate pro-recovery social policies, run anti-stigma campaigns, and offer needed recovery support services. In 2002, the program changed to the Recovery Community Services Program with a focus on the development of peer-based recovery support services.

Access to Recovery (ATR) program<sup>3</sup>. Also spreading are state and urban initiatives to transform addiction treatment into a “recovery-oriented system of care” led by the examples of the Connecticut Department of Mental Health and Addiction Services and the Philadelphia Department of Behavioral Health. Increased interest in recovery is also evident in the growing number and quality of scientific studies on the pathways and processes of long-term recovery from addiction as evidenced by special issues on recovery by the field’s peer-reviewed scientific journals, i.e., *Substance Use and Misuse*, *Journal of Substance Abuse Treatment*, and *Alcoholism Treatment Quarterly*.

All of this raises questions of what this recovery focus is all about and whether it constitutes something of great value that is being newly discovered or rediscovered, or whether it is a passing fad that will exert little influence on the future of addiction treatment. The purpose of this essay is to explore such questions by briefly reviewing the history of recovery as an organizing concept.

### **Recovery Mutual Aid: A Historical Synopsis**

American communities of recovery have a long and rich history. American recovery mutual aid societies date from eighteenth and nineteenth century abstinence-based Native American religious and cultural revitalization movements: recovery circles of the Delaware Prophets, Handsome Lake Movements, Shawnee and Kickapoo Prophet movements, the Indian Shaker Church, and early Sacred Peyote Societies that were later organized as the Native American Church (Coyhis & White, 2006). These societies provided culturally-mediated pathways of recovery from alcohol consumption-related problems that grew in the wake of the physical and cultural assault on Native American tribes.<sup>4</sup> A dramatic rise in overall per-capita American alcohol consumption between 1780-1830 (from 2 ½ gallons annual per capita to more than 5 gallons annual per capita—nearly 3 time current American alcohol consumption)(Rorabaugh, 1979) triggered the American temperance movement and a long series of recovery support structures: the Washingtonians (1840s), the Fraternal Temperance Societies (1850-1900), the Dashaway Association (1859), the Royal and Blue Ribbon Reform Clubs (1870s), and such religiously oriented recovery groups as the Drunkard’s Club (1870), the Jacoby Club (1910), and the United Order of Ex-Boozers (1914) (White, 2001; Dubiel, 2004).

Today’s Twelve Step recovery programs date to the 1935 founding of Alcoholics Anonymous. The history of A.A. has been marked by a progressive growth in overall

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<sup>3</sup> The Access to Recovery (ATR) Program is the product of a 2003 Presidential initiative that is now administered by the Center for Substance Abuse Treatment. The ATR program provided vouchers to people seeking addiction treatment and/or recovery support services so that they could choose those services that best suited their needs and circumstances. More than \$100 million a year in ATR funds are channeled through state and tribal organizations.

<sup>4</sup> The role of historical trauma and colonization in the rise and maintenance of Native American alcohol consumption problems has been explored in considerable depth by Coyhis & White (2006), Brave Heart, & DeBruyn, 1998; Brave Heart, 2003; and Morgan, 1983. These sources document the role of alcohol in the economic, political and sexual exploitation of Native Americans; the creation of “firewater myths” as an instrument of colonization; and the Native American religious and cultural revitalization movements through which Native Americans resisted and responded to alcohol consumption problems. The latter movements include the Prophet Movement among the Delaware, Shawnee and Kickapoo; the Handsome Lake Movement, the Native American Temperance Movement, the Indian Shaker Church and the early Peyote Societies that evolved into the Native American Church.

membership and the number of registered groups, a diversification of A.A. member characteristics (by age, gender, ethnicity, sexual orientation, occupational background, and co-occurring problems), and a growing diversity of styles of recovery within A.A. A.A.'s Twelve Steps have been adapted to create anonymous recovery programs for those with other drug choices: narcotics (1948, 1953), marijuana (1968 & 1989), pills (1975 & 1998), cocaine (1982), nicotine (1985), benzodiazepines (1989), methamphetamine (no founding date available) and heroin (2004). Twelve step addiction recovery groups have also been created that transcend drug choice categories such as Chemically Dependent Anonymous (1980) and Recoveries Anonymous (1983) (Kurtz E., Kurtz L., & White, in press), and applied to a multitude of other human problems, e.g., Gamblers Anonymous, Overeaters Anonymous, Debtors Anonymous.

Modern alternatives to Twelve Step addiction recovery programs began in the mid-1970's and grew rapidly throughout the 1980s and 1990s. Such alternatives include:

- gender-specific recovery groups (Women for Sobriety, 1975; 16 Step Discovery & Empowerment groups, 1991; Mothers on Methadone, 2005),
- secular alternatives to Twelve Step Programs (Secular Organization for Sobriety/Save Our Selves, 1985; Rational Recovery, 1986; Men for Sobriety, 1988; LifeRing Secular Recovery, 1999; SMART Recovery®, 1999),
- explicitly religious alternatives to Twelve Step Programs (Alcoholics for Christ, 1976; Celebrate Recovery, 1990; One Addict—One Church, 1994; Millati Islami), and
- moderation-based support groups (Methods of Moderation and Management, 1983; Moderation Management, 1994) (Kurtz E., Kurtz, L., & White, W., in press).

It can be seen from this review that organized frameworks of recovery predate the birth, and have existed independent of, addiction treatment institutions, the latter marked by the opening of the first inebriate home (1857), inebriate asylum (1864), and private addiction cure institute (1879) (White, 1998). For more than 250 years, these recovery societies have relied on recovery support strategies that include such actions as public confession; public commitment to abstinence; sober fellowship through regular and sustained participation in experience-sharing meetings and related social activities; the discovery of previously hidden resources within and/or beyond the self; a reconstruction of personal values, identity and interpersonal relationships; and service to others as a mechanism of self-healing (White, 1998; Kurtz, Kurtz, & White, in press).

Throughout this history, debate has continued as to whether the process of resolving alcohol and other drug use-related problems is one of reform, redemption, recovery, reconstruction, maturation, or transformation. Since contentions that those in the Washingtonian movement should be called “reforming” rather than “reformed” (Harrison, 1860), debate has continued over whether this resolution is best thought of as a point in time event (e.g., a decision, an act such as signing a temperance pledge) or an ongoing process. Recovery has been the central organizing concept for recovery support groups, but that has not always been the case for addiction treatment institutions treating a broad range of substance users who represented a heterogeneous population of people.

### **Recovery Mutual Aid and Professional Treatment**

The relationship between addiction treatment institutions and recovery mutual aid organizations is a complex and ambivalent one. The therapeutic branch of the American temperance movement called for the rescue of inebriates through outreach from temperance societies and the creation of specialized institutions for the care of the inebriate (Woodward, 1836). A network of inebriate homes, inebriate asylums and private addiction cure institutes rose on the American landscape in the mid-nineteenth century before collapsing in the opening decades of the twentieth century (White, 1998). These early institutions saw themselves

providing treatment that would “cure” the “*disease of inebriety*,” and gave little thought to the post-institutionalization adjustment process. When these early institutions closed, decades of public education and advocacy (the “*modern alcoholism movement*” of the 1940s through the 1960s) were required to rebirth today’s national network of addiction treatment programs.

Throughout this history, there has been a complex and mutually ambivalent relationship between professionally-directed treatment institutions and peer-based recovery mutual aid societies. Addiction treatment programs have been spawned by recovery mutual aid societies. The Home for the Fallen (1857) was founded by the Washingtonians and later re-opened as the Washingtonian Home, and the Dashaways established the San Francisco Home for the Care of the Inebriate (1859) (White, 1998). Once established, these institutions tended to become medicalized and professionalized and progressively detached from their founding bodies.

There were also institution-based recovery mutual aid groups formed by the patients being treated at these institutions. Such groups, what today would be called “consumer councils” or “alumni associations,” included the Ollapod Club (1868) founded at the New York State Inebriate Asylum, the Godwin Association (1872) founded at the Franklin Reformatory Home for Inebriates in Philadelphia (White, 2001), the Keeley League (1891) founded within the Keeley Institute (Barclay, 1964), and the Jacoby Club (1910), which was associated with the Emmanuel Clinic in Boston (Dubiel, 2004).

The complex relationship between addiction treatment and recovery mutual aid groups is most evident in the history of Alcoholics Anonymous (AA) and modern addiction treatment. Several of AA’s character-shaping events occurred in the context of treatment: psychiatrist Carl Jung’s refusal to readmit Roland Hazard as a patient and Bill Wilson’s climactic spiritual experience at Charles Towns Hospital. AA co-founder Bill Wilson was offered a paid position as a lay alcoholism psychotherapist (which he declined), and AA had plans for founding alcoholism treatment hospitals (which it later abandoned) (White & Kurtz, in press). The potential difficulties of mixing mutual aid with professional treatment or policy advocacy led to AA’s policies of singleness of purpose and non-affiliation with outside enterprises and controversies. Given earlier histories of addiction treatment institutions colonizing mutual aid societies for their own purposes (e.g., the collapse of the Keeley League following their takeover by the Keeley Institute founder), AA’s position seems a historically wise one.

There is a delicate and difficult to sustain balance in the relationship between addiction treatment institutions and recovery mutual aid societies. If treatment and recovery support institutions become too close or are merged, there is a tendency for one of these critical functions to be lost. Either treatment ceases being treatment and becomes that which is available for free outside of professional service settings, or recovery support becomes professionalized and ceases being based on mutual vulnerability and shared recovery experience. If treatment and recovery support institutions become too distant from one another, mutual aid members lose their access to needed treatment and treatment graduates lack connection to ongoing recovery supports. Historically, both recovery mutual aid and professional treatment have value, but destroy themselves when they lose their identity and boundary integrity (White & Kurtz, in press). When mutual aid members provide “treatment” they exceed the boundaries of their education, training and experience and threaten harm and injury to those they serve. When treatment becomes nothing but mutual aid, it offers a paid professional service what its consumers can receive in the larger community without cost. Treatment relationships are externally-regulated (by government and voluntary licensing and accreditation standards governing treatment institutions, professionally-grounded (by ethical codes of the professions represented in the service team), fiduciary (one party assuming ethical and legal obligation for the care of another), commercialized (someone is paying the helping institution and helping provider) and usually time-limited. Recovery mutual aid relationships are internally regulated (governed by organizational values of group conscience), reciprocal, non-commercialized and potentially enduring.

Through the processes of professionalization (the evolution of addiction counseling from a folk art provided by indigenous recovering people to a profession governed by educational, licensure and accreditation standards promulgated by external bodies) and industrialization (the evolution of addiction treatment institutions from community-based service organizations to highly regulated businesses) modern addiction treatment as an activity and a field of professional endeavor became disconnected from the larger process of recovery and from indigenous communities of recovery. That disconnection is evident in changes in the addiction field perceived by the author in his travels (100+ days per year) as a trainer and consultant with addiction treatment programs over the past 35 years (See White, 1998 for discussions of the evolution of modern addiction treatment). Those changes include:

- declining percentage of recovering people working in the field in administrative and clinical positions,
- decreased recovery representation on treatment institution boards,
- abandonment of service advisory boards made up mostly of recovering persons,
- diminished expectation that treatment professionals would attend local open meetings of mutual aid societies,
- loss of recovery-based volunteer programs,
- decline of alumni programs,
- abandonment of formal meetings between addiction treatment institutions and the formal service structure (e.g., hospitals and institution committees) of mutual aid groups, and the
- shift from assertive linkage procedures (to a particular person or meeting or taking a person to one or more meetings) to passive linkage procedures (verbal encouragement to attend recovery support meetings) between addiction treatment and recovery mutual aid societies.

Several long-time observers of addiction treatment have noted the deterioration of the connective tissue linking the worlds of addiction treatment and recovery mutual aid and have called for renewing these relationships (Zweben, 1986; Morgan, 1995; White, 1996; Else, 1999). Considerable effort is currently underway to re-instill assertive linkage procedures between addiction treatment programs and American communities of recovery (White & Kurtz, 2006).

### **Towards a Recovery Paradigm**

The intensification of interest in recovery marks a shift from pathology and intervention paradigms to a solution-focused paradigm. The knowledge base of the “addictions field” or “treatment field” has been drawn primarily from a study of pathology. The field’s knowledge of toxico-pharmacology, the neurobiology of psychoactive drugs, the etiology and patterns of alcohol and other drug (AOD) use -related problems, and professional interventions into AOD use-related problems is immense in terms of scientific data and publicly accessible information. There are admittedly significant problems in the gap between knowledge drawn from research within these pathology and intervention paradigms and front line clinical practice—a problem further complicated by the highly politicized environment surrounded AOD use-related problems. But what is being suggested here is something quite different: that the knowledge base from which knowledge is being drawn to influence clinical practice lacks a central sphere of investigation. As a field, we have all manner of organizations and journals whose names reflect our focus on the problem, but not a single federal or state agency and not a single journal whose name declares its singular focus on recovery. Would a National Institute on Addiction Recovery operate differently than a National Institute on Drug Abuse? Would a *Journal of Addiction Recovery* address different questions than existing publications such as the *Journal of Psychoactive Drugs* or the *Journal of Substance Abuse Treatment*? The field has yet to shift to a

paradigm centered on the solutions to AOD use-related problems for individuals, families, and communities.

Prevalence data on recovery is miniscule compared to the mass of data on drug use trends and drug use-related casualties (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Little is known about the pathways, styles, and stages of long-term problem resolution and how these vary across demographic and clinical subpopulations (White, 2004a). There is considerable literature on how various posited risk factors<sup>5</sup> can increase vulnerability for addiction and compromise recovery outcomes, but little research on how different types of recovery capital can offset such risk factors and mediate recovery among even those with the most severe problems (Laudet & White, in press). A consistent theme of the Center for Substance Abuse Treatment's recent Recovery Summit was the need for a recovery research agenda that would illuminate successful long-term solutions to AOD problems. As we will see shortly, the evolution to a recovery paradigm has significant clinical implications for the design and evaluation of addiction treatment, but there is a dearth of data to guide that evolution.

Addiction treatment as historically designed has been focused on brief biopsychosocial stabilization, not sustainable long-term recovery. This acute care (emergency room) model is distinguished by several key characteristics:

- 1) problem intervention is marked by an encapsulated and prescribed series of professional activities (screen, assess, diagnose, admit, treat, discharge, terminate the service relationship),
- 2) a professional expert directs the process,
- 3) services transpire over a short (and historically ever-shorter) period of time, and
- 4) the individual/family/community is given an impression at discharge ("graduation") that full recovery is now attained and self-sustainable without ongoing professional assistance.

The acute care model of addiction treatment does generate sustainable abstinence through typically short (1-3 year) follow-up periods for a minority of individuals (one-fourth to one-third) thus treated and substantial reductions in the frequency of drug use among others (Miller, Walters & Bennett, 2001), but slogans like "Treatment Works" mask fundamental problems with this model.

Among the major problems of the acute care model of addiction treatment are its failure to acknowledge people who resolve alcohol and other drug use problems without professional intervention (and distinguish those who need and do not need professional intervention), low voluntary attraction (resulting in typically late stage problem intervention), obstacles to access (e.g., waiting lists), attrition (more than 50% of persons admitted fail to successfully complete), inadequate service quality (Magura, 2000), inadequate service dose (less than that prescribed in NIDA's *Principles of Addiction Treatment*), exposure to treatment methods proven to have minimal or even harmful effects<sup>6</sup> (see White, 1998 & Moos, 2005 for historical and contemporary reviews on the latter), post-treatment relapse (more than 50% of those treated and followed at one to five year intervals following discharge), and treatment readmission (See

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<sup>5</sup> This concept, (and its 'first-cousin, "protective factors). often noted in the literature, is all-too-often used without adequately understanding and considering its dimensions ( linear, non-linear), its "demands", the critical necessary conditions which are necessary for it to operate (begin, continue, become anchored and integrate, change as de facto realities change, cease, etc.) or not to and whether its underpinnings are theory-driven, empirically-based, individual and/or systemic stake holder- bound, based upon "principles of faith" or what. What is necessary – endogenously as well as exogenously for a "risk" process to operate? This is necessary to clarify if the term is not to remain as yet another shibboleth in a field of many stereotypes. If we don't currently know, in a generalizable sense- it behooves us to state this. Editor's note.

<sup>7</sup> Common treatment methods with little or no evidence of their effectiveness include lectures, educational films, general alcoholism counseling and milieu therapy ( Wilbourne & Miller, 2002); an example of potentially harmful interventions include confrontational counseling techniques (See Whittr & Miller, 2007 for a review.)

White, 2005c for a review). The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admissions, including 22% with 3-4 prior admissions and 19% with 5 or more prior admissions (SAMHSA-OAS, 2005). Between 25-35% of clients discharged from addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within 2-5 years (Simpson, Joe, & Broome, 2002).

It is quite clear that a growing number of people are entering addiction treatment in the United States whose problem severity, complexity and chronicity, and low recovery capital are not being fundamentally altered via this acute care model of intervention. The American treatment system has repeatedly and erroneously interpreted brief, professionally facilitated biopsychosocial stabilization as sustainable recovery. Such episodes are as likely to be a milestone in one's addiction career as a milestone of entry into the recovery process, as the public parade of celebrities heading back to boutique rehabs regularly demonstrates. The continued misrepresentation of the likely outcomes of the acute care model of professionally-directed addiction treatment has potentially ominous consequences. Such misrepresentation to service consumers and their families, referral sources, policy makers, and the public risks a backlash that could revoke addiction treatment's probationary status as a cultural institution. The acute care model of addiction treatment is culturally and clinically unsustainable.

The design of addiction treatment—particularly for those with the most severe AOD problems--should be radically altered if the goal and focus of treatment shifted from brief stabilization to sustainable recovery. If addiction treatment was really designed to support sustainable recovery, it would require abandonment of several mainstream clinical practices, e.g., conveying the impression that all clients should achieve permanent abstinence following brief treatment (and punishing them when they fail to achieve this goal), administratively discharging clients for confirming their diagnosis (see White, Scott, Dennis, & Boyle, 2005), and terminating the service relationship following brief contact—a practice that would be unthinkable in the treatment of any other chronic health care problem. Concepts such as graduation, discharge, and aftercare (as currently conceptualized) would be similarly abandoned for those with severe and persistent AOD problems.

For treatment to foster sustainable recovery, the following strategies would be required:

- thresholds of access and engagement would be lowered,
- therapeutic alliances would be strengthened and sustained and should focus as well, not only on the substance user patient but also on the change agent, which is rarely if ever done,
- global, continuing, and strengths-based assessment would be the norm,
- professionally-directed treatment plans would be replaced by, or rapidly transition to, client-generated, partnership-drive recovery plans (See Borkman, 1997),
- peer-based recovery support service roles would be integrated into the multidisciplinary treatment team,
- assertive linkage to, and monitoring of the relationship with, communities of recovery would be a routine practice,
- considerable attention would be placed on the recovery environment of each client with new roles devoted to enhancing each client's external recovery capital,
- treatment programs would form alliances with culturally indigenous recovery support institutions (e.g., churches, cultural revitalization movements), and
- sustained (up to five years) post-treatment recovery checkups (monitoring, support and early re-intervention) would be the norm in addiction treatment (White, 2005b).

Such strategies would require a sustained commitment for recovery focused training and technical assistance for addiction professionals and policy makers, and may require nothing short of major system transformation efforts (Kirk, 2007; Evans, 2007).

The earliest steps in this recovery-focused revolution in clinical policies and practices are already underway at national, state, and local levels (Clark, 2007; Kirk, 2007; Evans, 2007). The future of addiction treatment as a cultural institution hinges on the outcome of these system transformation efforts. Such efforts have been aided by evidence on the chronicity of certain patterns of addiction (McLellan et al., 2000), evidence on the fragility of post-treatment recovery (Scott, Foss, & Dennis, 2005), evidence that sobriety is not fully stabilized until 4-5 years into the recovery process (Jin, Rourke, Patterson, Taylor, & Grant, 1998; Dennis, Foss, & Scott, under review), and evidence that sustained post-treatment monitoring and support can significantly elevate long-term recovery outcomes (Dennis, Scott, & Funk, 2003; McKay, 2005). Post-treatment recovery check-ups have been shown to reduce time to treatment re-admission, increase the dose of treatment following re-admission and increase the prospects of transitioning to stable recovery (Dennis, Scott, & Funk, 2003; Scott, Dennis & Foss, 2005). It has been further suggested that this revolution in thinking and practice may offer special advantages to communities of color and other historically disempowered communities (White & Sanders, in press).

### **System Transformation Obstacles**

The recovery oriented transformation of addiction treatment faces significant obstacles and pitfalls, including major weaknesses in the infrastructure of addiction treatment that may require sustained monitoring and support parallel to that recommended above for individual clients leaving addiction treatment (McLellan, Carise, & Kleber, 2003). Implementation obstacles include conceptual fuzziness of recovery<sup>7</sup> and its related concepts (Betty Ford Institute Consensus Panel, in press; White, in press), funding streams and regulatory requirements designed exclusively to support service elements *within* the acute care model, service provider defensiveness, resistance to changes in clinical policies and practices, and lack of scientific research on key recovery-related questions. Some of the most successful strategies of addressing these obstacles include building a strong collation of policy makers, treatment providers and recovery advocacy organizations; honoring what people have done in the past; rigorously evaluating current service practices; generating a shared vision, core values and a planning and implementation process for systems transformation; garnering additional funds to enhance service redesign and new initiatives; providing sustained training to all system stakeholders; and developing a formal communication strategy related to systems transformation that constantly links discrete initiatives to the larger transformation vision and process (Kirk, 2007; Evans, 2007).

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<sup>7</sup> Examples of such fuzziness include questions of whether recovery includes an altered relationship with all psychoactive substances—including tobacco, whether the recovery concept embraces problem resolution strategies other than abstinence, whether recovery encompasses medication assistance (e.g., methadone, naltrexone), whether recovery requires more than a resolution of alcohol and other drug use problems, and whether recovery is an all or none concept or whether it is something that could be achieved partially. See White, in press, for a detailed discussion of such questions.

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### **Institutions to Contact for Further Information**

Faces and Voices of Recovery ([www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org))  
 Behavioral Health Recovery Management project ([www.bhrm.org](http://www.bhrm.org))  
 The Great Lakes Addiction Technology Transfer Center ([www.glattc.org](http://www.glattc.org))  
 The Northeast Addiction Technology Transfer Center ([www.neattc.org](http://www.neattc.org))  
 The Network for the Improvement of Addiction Treatment ([www.niatx.net](http://www.niatx.net))  
 The Connecticut Department of Mental Health and Addiction Services  
 (<http://www.ct.gov/DMHAS>)  
 The Philadelphia Department of Behavioral Health  
 (<http://www.phila.gov/dbhmr/>)

### **Glossary**

*Recovery* is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) use-related problems mobilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by these problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, in press).

*Recovery capital* is the total of internal and external assets that can be drawn upon to initiate and sustain the resolution of alcohol and other drug problems (Granfield & Cloud, 1999).

*Recovery check up* is a systematic way to monitor post-treatment progress, provide stage-appropriate recovery education, provide linkage to needed community resources, and to provide, when needed, early re-intervention.

*Recovery coach* is a recovery-informed person that offers non-clinical recovery support services to persons seeking to initiate and sustain long-term recovery from severe alcohol and other drug use problems.

*Recovery management* is the stewardship of personal, family, professional and community resources to achieve the long-term resolution of severe alcohol and other drug *use-related* problems (White, Boyle, & Loveland, 2002).

*Recovery paradigm* is the use of knowledge derived from the experience of recovering people and recovery-focused research to design addiction treatment and long-term recovery support services.

*Sustainable long-term recovery* is the stable resolution of alcohol and other drug use problems in tandem with improvements in emotional and relational health for more than five years.

*Solution-focused paradigms* are organizing models that place emphasis on building personal, family and recovery assets rather than on the diagnosis of personal, family and community pathologies.