



Selected Papers of William L. White

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Phoenix House Consultation Questions & Responses

William L. White

Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

1. Besides a recovery support group prior to admission for engagement what other ways can treatment providers engage clients earlier?

I think the most important of these include:

- Assertive outreach programs in hospitals, jails, shelters, needle exchanges—including street outreach conducted by teams of recovering volunteers (some of these are being conducted by consumer councils and alumni associations).
- Assertive waiting list management via assignment of recovery coach to engage, encourage, start treatment activities prior to formal admission, resolve obstacles to admission, resolve ambivalence about admission, etc.
- Assignment of “strength” (a senior client) to each client at point of intake to serve as recovery coach, e.g., coaches can engage and orient client prior to staff assessment and intake; senior clients benefit via “helper principle.”
- Using senior staff to induct/indoctrinate new clients.
- “Institutional outreach” (regularly checking in with people) to then sustain engagement and retention

Resource: See chapter on engagement in: 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; DeLeon, G., Hawke, J., Jainchill, N., & Melnick, G. (2000). Therapeutic communities: Enhancing retention in treatment using “Senior Professor” staff. *Journal of Substance Abuse Treatment*, 19, 375-382.

2. Have you heard of SMART recovery groups and if so what do you think of the utilization of these recovery groups in conjunction with NA and AA support groups?

Yes, I serve on the scientific advisory board of SMART Recovery and have also collaborated with Secular Organization for Sobriety, LifeRing Secular Recovery and other secular recovery support groups.

Response to all recovery support groups—like all treatment approaches—vary from optimal response, partial response, no response, and adverse response. The trick becomes one of matching the person to a particular community of recovery. The secular recovery support group memberships would indicate their viability for individuals marked by higher levels of education and individuals low in spiritual or religious orientation. More and more programs are moving toward a “philosophy of choice” related to long-term pathways of recovery. Offering choice is limited by the lack of alternatives to 12 step groups in many communities, but dispersion of these alternatives is increasing and online recovery support meetings are growing very rapidly.

Resource: White, W. and Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, 6(4), 58-61; Horvath, A. (1999-2000). SMART Recovery. *International Journal of Self Help and Self Care*, 1(2), 163-169; White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor*, 9(1), 38-43.

3. Where can treatment providers get self guided recovery management materials?

These are just beginning to be developed. The place that is doing it most systematically is the Philadelphia Department of Behavioral Health via their Tools for Transformation. Recovery advocacy organizations are also beginning to develop such materials, e.g., PRO-ACT in PA and CCAR in CT.

I have also prepared some self-assessment recovery planning tools as part of a larger “toolkit” that I will send to Jennifer and David for distribution.

Resource: For Tools of Transformation info, see Ellen Faynberg at Ellen.Faynberg@phila.gov or 215-685-5463; For materials from PRO-ACT and CCAR, contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771 at PRO-ACT or Phil Valentine at phillip@ccar.us at CCAR.

4. Engaging and maintaining voluntary consumer councils, advisory boards, and alumni associations, which are vital sources of support, is difficult for obvious reasons. What successful methods have you seen?

The most dynamic consumer council I have seen is the NET Consumer Council in Philadelphia. Here is a profile of their Council.

Program Profile: NET Consumer Council (NorthEast Treatment Centers, Philadelphia, PA)
<u>Purpose:</u> Enhance client participation in agency policy development and ownership of their own recovery processes.
<u>Service Elements:</u> 1) weekly Consumer Council meetings with, 2) Monthly Consumer Recognition Day, 3) <i>Recovery Focus</i> , a bi-monthly consumer council newsletter, 4) consumer peer mentor program (peer mentor assigned to all new clients), 5) consumer volunteer program (outreach and community service work), 6) Community Living Program (a consumer-directed recovery skills training and recovery coaching program delivered to men residing in the NET Wharton Center, an inpatient residential rehabilitation program), 7) The NET Community Recovery Center (a consumer-operated drop-in center), and 8) the consumer speakers bureau.
<u>Service Volume/Status:</u> Since its creation in August 2006, 90%+ participation from 14 revolving CC representatives; average of 120 consumers at monthly consumer recognition dinner.

Service Outcomes: Increased daily attendance rates, completion rates and successful rates of transfer to another level of care; decreased power struggles between clients and staff; greater client involvement in treatment.
Service Lessons: Empowering clients increases personal motivation for recovery and also increases motivation for professional staff; outreach moves recovery into the life of the community.
For More Information: Joseph Schultz (jschultz@net-centers.org)

There are also some very good models for Alumni Associations, a few of which are profiled in: White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC

Resource: The Net Consumer Council, Evans, A.C., Lamb, R.C., Mendelovich, S., Schultz, C.J. & White, W.L. (2007). *The Role of Clients in a Recovery-oriented System of Addiction Treatment: The Birth and Evolution of the NET Consumer Council*. I will email this paper to Jennifer and David for distribution.

5. Have you seen treatment systems that have made effective use of paraprofessionals or the public recovery community, while minimizing some of the obvious pitfalls? Has any standardized model of training for a paraprofessional Coach or Community Recovery Partner been designed?

There is a resurgence in recruitment of recovering people in paid and volunteer roles to provide peer-based recovery support services within addiction treatment organizations. There is also the growing phenomenon of private, fee-based recovery coaching offered most commonly by interventionists.

There are some recovery coach training manuals (See www.bhrm.org) and there are some effective training programs being launched as part of recovery-focused systems transformation efforts or offered privately—sometimes for outlandish fees.

Program Profile #: Peer Leadership Academy (PLA, Philadelphia, PA)¹
Purpose: To train individuals and family members in recovery to assume leadership roles in Philadelphia’s recovery-focused systems transformation process
Elements: 26 week training program
Service Volume/Status: effort spans recovery from addiction, mental illness and co-occurring disorders; 60 individuals have been trained by four faculty members; College credits are provided for completion of training.
Outcomes: survey of graduates revealed a total of 740 hours of voluntary community service in past 9 months—a 40% increase over pre-training levels; graduates reporting a total of 40 community presentations made since completion of training.
Lessons Learned: 1) increase in volunteer hours seems to be related to increased self-confidence of graduates, 2) PLA has provided a pool of effective volunteers to serve on key recovery advisory committees in Philadelphia, 3) quality of committee participation has increased in tandem with their skills, confidence and assertiveness, 4) having volunteers intern with committees provides great preparation for full membership on committees, 5) positive feelings of graduates toward the PLA is now the primary recruitment vehicle for new recruits.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

¹ Personal communication with Bev Haberle, December 2008
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Resource: White, W. (2006). *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity*. (Monograph) Philadelphia, PA: Philadelphia Department of Behavioral Health; White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

I can email these two papers to anyone who would like copies.

6. What is meant by "social marketing of AOD problem-resolution options and successes," specifically the term "social marketing"?

"Social marketing" as I have used the term is a strategy aimed at elevating community knowledge about and attitudes toward addiction recovery. Key messages here are that long-term recovery is a reality in the lives of millions of individuals and families, that there are many pathways to recovery, that recovery thrives in supportive communities, and that recovery gives back to individuals, families and communities what addiction has taken. Note: These campaigns are not primarily about addiction or about treatment; they are about RECOVERY, and include such information as the prevalence of recovery; religious, spiritual and secular pathways to recovery, the role of treatment in recovery, styles of recovery, stages of recovery, how others can support recovery, etc.

Resource: White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.

7. To overcome the myths of "cure," and the medicalized acute treatment episode, don't you think that programs and professionals will need to revamp the entire conceptualization of treatment, and change a lot of terminology?

Absolutely. As we shift from pathology models (addiction) and intervention models (treatment) to solution models (recovery), there are words we will need to cast aside (e.g., "aftercare") and a whole new lexicon that will come into common use, e.g., recovery management, recovery oriented systems of care, recovery priming, recovery capital, recovery planning, recovery coach, peer-based recovery support services, to name just a few.

Resource: 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. (2002) *An Addiction Recovery Glossary: The Languages of American Communities of Recovery*. www.facesandvoicesofrecovery.org; also included in: White, W. (2006). *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

8. What are the first five things you would do as a program director to begin promoting this concept or perspective of treatment at your facility.

My first 5 list might change depending on which day you asked me, but I'm sure these 5 would always be in my top 10.

1. Create a Recovery Advisory Board, including alumni, current consumers, and recovery community representatives (individuals and family members) to guide the agency transformation process.

2. Orient (over a period of months) all board members, staff, consultants and volunteers to research findings on long-term recovery and the recovery management model.
3. Create an internal task force to conduct a “fearless and searching” inventory of all clinical practices to evaluate their relevance to long-term recovery and to develop a plan to achieve more recovery-focused policies and practices.
4. Develop protocol for assertive linkage to local communities of recovery and monitor fidelity to such protocol by all staff.
5. Develop a program for post-treatment monitoring, stage appropriate recovery education, recovery coaching, and, when needed, early re-intervention for all clients admitted to treatment—with saturated support in first 90 days following primary treatment and at least annual recovery check-ups spanning the first 5 years of recovery.

Resource: White, W. (2005). Recovery Management: What if we really believed addiction was a chronic disorder? *GLATTC Bulletin*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, September, pp. 1-7.

9. Research on the most effective lengths for Recovery Management programs for adults.

We have reliable data only for adults on the question of, “When is recovery stable and durable, e.g., when does sobriety today predict lifelong sobriety? The key window of stability (point at which the risk of future lifetime relapse drops below 15% is between 4-5 years, although the relapse rate after 5 years is higher in recovery from opiate dependence than for alcohol dependence, suggesting monitoring (recovery checkups) for some groups might be indicated beyond 5 years..

Resource: De Soto, C.B., O’Donnell, W.E., & De Soto, J.L. (1989). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research*, 13, 693-697. Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry*, 53(3), 243-249. Nathan, P., & Skinstad, A. (1987). Outcomes of treatment for alcohol problems: Current methods, problems and results. *Journal of Consulting and Clinical Psychology*. 55, 332-340. Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20(4), 771-779. Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J., & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol*, 59, 640-646. Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, 31(6), 585-612. Schutte, K., Byrne, F., Brennan, P., & Moos, R. (2001). Successful remission of late-life drinking problems: A 10-year follow-up. *Journal of Studies on Alcohol* 62, 322-34.

For the higher risk of opioid relapse after five years, see: Simpson, D.D., & Marsh, K.L. (1986) Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims, & C. Luekefeld, *Relapse and recovery in drug abuse* (NIDA Monograph 72). Rockville, MD: National Institute on Drug Abuse. Hser, Y.I., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58, 503-508.

10. Is Peer lead better vs staff lead?

If by peer, you mean recovery, there is no evidence that recovering people versus non-recovering people differ in effectiveness performing the same clinical functions. Such effectiveness differs greatly from individual to individual but is not determined either by recovery status or education.

If by peer, you mean other clients in treatment, there is almost no research on this question.

I suspect we will find in both areas that recovering staff without extensive professional training and treatment peers can play a significant role in attraction, engagement, enhancing retention and providing experience-based advice on long-term recovery decision-making and that traditional professionals not in recovery will play three critical roles: assisting as they do now with the process of biopsychosocial stabilization, treating co-occurring medical and psychiatric disorders, and then, interestingly, offering guidance well into the recovery process on character reconstruction and the reconstruction of family and intimate relationships. In short, the question will change from, “Are recovery peers or professional staff more effective in influencing recovery outcomes?” to “Which roles are superior for what functions and at what particular stages of recovery.

Resource: White, W. (Drafted, release in spring 2009). *Peer recovery support: History, theory, practice and scientific findings*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

11. What’s the most effective Adolescent Recovery Management research and effective programs.

I’m partial to the Adolescent Community Reinforcement Approach because it addresses intrapersonal, interpersonal and environmental dimensions of adolescent recovery, attempts to create a recovery-conducive post-treatment milieu, and incorporates very assertive approaches to post-treatment continuing care.

Resource: Godley, M.D., & Godley, S.H. (in press). Continuing care following residential treatment: History, current practice, and emerging approaches. In N. Jainchill (Ed.), *Understanding and treating adolescent substance use disorders*. Kingston, New Jersey: Civic Research Institute; Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32; Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, 102, 81-93; Godley, M. D., Kahn, J. H., Dennis, M. L., Godley, S. H., & Funk, R. R. (2005). The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis use or dependence. *Psychology of Addictive Behaviors*, 19(1), 62-70; Godley, S.H., Dennis, M.L., Godley, M.D., & Funk, R.R. (1999). Thirty-month relapse trajectory cluster groups among adolescent discharged from out-patient treatment. *Addiction*, 99(Suppl 2), 129-139; Godley, S. H., Godley, M. D., & Dennis, M. L. (2001). The assertive aftercare protocol for adolescent substance abusers. In E. Wagner, & H. Waldron, (Eds.), *Innovations in adolescent substance abuse interventions* (pp. 311-329). New York: Elsevier Science Ltd.

For information on assertive linkage of adolescents to recovery support groups, see: Passetti, L. L., & White, W. L. (2007). Recovery support meetings for youths: Considerations when referring young people to 12-step and alternative groups. *Journal of Groups in Addiction and Recovery*, 2, 97-121.

12. What are your recommendations regarding specific methods on connecting assessments, treatment planning and placement levels of adults versus teens.

My primary interests in this area have been on helping my colleagues develop a comprehensive assessment instrument (the GAIN) and how we transition from staff directed treatment plans to client-directed recovery plans. As for linking assessment and placement levels, I have been investigating the interaction of problem severity/complexity and recovery

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capital should influence level of care placement and intensity and duration of in-treatment and post-treatment recovery support services. I am particularly interested in how the assessment of community recovery capital could enhance placement and recovery planning decisions.

Resource: White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27; White, W., Kurtz, E. & Sanders, M. (2006). *Recovery Management*. (Monograph) Chicago, IL: Great Lakes Addiction Technology Transfer Center. For info on the GAIN, See www.chestnut.org.

13. What is your view of benefits and liabilities of community-based treatment, such as wrap-around for teens versus segregated residential treatment?

I think wrap around models are effective strategies for creating multi-agency, interdisciplinary teams to address the needs of multiple-problem adolescents and families. Two deficiencies of these models are that they 1) tend to only focus on the integration of formal professional agencies and neglect indigenous healers and indigenous institutions that can be critical to long-term recovery, and 2) they have a tendency to emphasize coordination and case management without an adequate focus and dose on primary treatment. Regarding point 2, I have seen clients with 4 case managers but no one doing primary treatment. The strength of the better of these models I have evaluated is in engagement and problem stabilization; their weakness is in assuring adequate recovery initiation (a lot of so-called relapse is more aptly described as continued drug use; relapse can't occur until after a period of recovery initiation) and sustaining support through the transition from recovery initiation to recovery maintenance and enhanced quality of life in long-term recovery.

Resource: White, W. (in press). The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.

14. As more communities are shifting funding away from adolescent residential settings and replacing it with wrap-around, what is your viewpoint or your specific positions on the longer-term consequences of such decisions?

This shift will meet the needs of adolescents/families presenting with low/moderate problem severity and moderate/high recovery capital, but will fail markedly with adolescents/families presenting with high problem severity/complexity and low recovery capital. The long-term consequence will be that the adolescents in this latter groups will be abandoned to systems of control and punishment. And they will be blamed for failing to respond to structures whose service intensity and duration provided no likelihood of successful recovery initiation and maintenance. That process has already been underway since the heightened restigmatization, demedicalization and criminalization of AOD problems since the "zero tolerance" philosophy of the 1980s.

Resource: White, W. (in press). The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.

15. I would ask what Bill has seen, through his experience and research, as the most effective components of recovery management in the community for adolescents following short or long term residential treatment as well as youth who have participated in outpatient care.

I have seen a wide variety of such components. My favorite include:

- the earlier-noted system of recovery checkups
- recovery community development strategies that seek to increase young peoples meetings and sober social activities

- special linkage procedures to recovery support groups (See Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs*, 40, 29-40.)
- recovery support groups in schools—often delivered through student assistance programs
- recovery schools
- recovery homes for adolescents
- (There is much discussion about the potential of telephone- and internet-based recovery support services for adolescents.)

Resource: White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58; Godley, S. & White, W. (2006). Student assistance programs: A valuable resource for substance-involved adolescents. *Counselor*, 7(2), 66-70; White, W. (Drafted, release in spring 2009). *Peer recovery support: History, theory, practice and scientific findings*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

16. In your view what is the best way to collect outcome data once clients leave treatment?

Clinical and research follow-up rates used to be so awful that we followed mostly those who didn't need it and collected data on samples completely unrepresentative of the whole. The really good news is that the field has developed very sophisticated strategies for maintaining almost indefinite contact with people following treatment. At Chestnut's research division, we routinely maintain 90%+ follow-up rates in studies following clients for up to 10 years following treatment. These approaches, which rely on very ingenious locator systems, maintaining regular contact with people even between follow-up interviews, incentivising continued contact on the part of the client, etc, have also been extensively described (See Scott & Dennis article below). I think the best approaches use rigorous collection and updating of locator data, use multiple follow-up media (face-to-face, mail, phone and internet), and assign trackers to locate clients who cannot be contacted via routine methods.

Resource: 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.

17. With recovery support services such as AA/NA being adult oriented, what do you view as the best recovery support activities for adolescents?

Passetti and Godley studied adolescent treatment center referral processes to recovery support groups and found the highest rates of successful linkage within programs that:

- emphasized the sober social activities sponsored by support groups (e.g., young peoples' conferences),
- worked with local support group service structures to identify particular meetings appropriate for young people,
- identified individuals to serve as role models and guides for young people,
- created networks of trusted people to accompany young people to meetings,
- monitored post-treatment attendance and response to meetings, and
- helped identify potential sponsors.

Little is known about the role of mutual aid factors other than meeting attendance on long-term adolescent recovery outcomes, e.g., having a sponsor, having a home group, step-work, etc.,

and even less is know about the role of participation in other recovery support institutions, although preliminary data on recovery schools looks very promising.

Resource: Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs*, 40, 29-40.

18. What is the most useful recovery support program you have witnessed?

There are few things that can match recovery mutual aid groups in terms of geographical accessibility, availability (24/7/365) and affordability (free). If a program director said I have a small amount of money to do only one thing—What should that one thing be (other than assertive linkage to mutual aid groups)? I would answer, “Invest in post-treatment recovery monitoring and recovery coaching for all clients during the first 90 days following discharge (regardless of discharge status.)

Resource: Scott, C. K., Dennis, M. L., & Foss, M. A. (2005a). Recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, 78, 325-338; Scott, C. K., & Dennis, M. L. (in press). Results from two randomized clinical trials evaluating the impact of Quarterly Recovery Management Checkups with adult chronic substance users. *Addiction*.

19. In our community-based women's programs, we ask that residents identify a "mentor" from the community who is a resource/support during their treatment episode and who will continue that role when she exits treatment. We have a broad definition of "mentor", including 12-step sponsor, church member, advocate, or other community member who agrees to accept that role. We require that this person come into the program for an interview with clinical staff prior to formalizing the relationship in the client's treatment plan. What comments/recommendations regarding this approach would you have?

I like this a lot. I think what we are seeking is long-term continuity of contact in a primary recovery support relationship as the glue that meshes all the other services and service relationships that are part of this thing we call treatment. Ideally that continuity of support spans pre-treatment engagement, in-treatment support, and post-treatment monitoring and support.

Resource: For scientific studies of sponsorship, mentor programs, and “companionship therapy”, see White, W. (Drafted, release in spring 2009). *Peer recovery support: History, theory, practice and scientific findings*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health.

20. What is your experience of faith-based systems as the extended recovery support plan?

There are religious, spiritual and secular frameworks of long-term recovery and all constitute legitimate pathways of recovery. We do not have data on the proportion of the total recovery population across these three broad categories. What is clear is that faith based recovery is on the increase, as evidenced by:

- “Recovery friendly churches” that welcome recovering people but offer no special recovery services
- Churches spawning new religiously sponsored recovery mutual aid groups, e.g., Celebrate Recovery, Victorious Ladies
- Mega-churches adding a “recovery pastor” to their staff
- Small churches using lay leaders and volunteers to lead recovery support meetings

- Church-sponsored, recovery-focused worship services, workshops, leadership training, and children's programs
- Recovery Churches, e.g., Central Park Recovery Church in St. Paul, Minnesota, the Recovery Church in Charlotte, North Carolina, and the Christian Recovery Fellowship in Dryden, Maine, for whom recovery is a central part of their identities as religious communities
- New faith-based recovery colonies (residential communities), e.g., Dunklin Memorial Camp in Okeechobee, Florida
- A new association of recovery ministries, i.e., the National Association for Christian Recovery (<http://www.nacronline.com>), and
- The growth of non-Christian recovery ministries and support groups, e.g., Millati Islami.

I think one of the most important contributions of faith-based recovery communities is the idea that recovery for some people comes not through incremental stages but as a climactic experience that is unplanned, positive and permanent—experiences that have their religious, spiritual and secular varieties. I think we need to know a lot more about how to recognize such experiences and guide these powerful recovery initiation experiences into sustainable long-term recovery.

Resource: White, W. & Whitters, D. (2005). Faith-based recovery: Its historical roots. *Counselor*, 6(5), 58-62; White, W. (2004) Transformational change: A historical review. *IN SESSION: Journal of Clinical Psychology*, 60(5), 461-470; White, W. (2004) Transformational change and addiction recovery. *Counselor*, 5(4), 30-32.

Questions That Arrived After Preparation for the Phone Consultation

21. How do we engage the staff in the transition from the TC to long term rehabilitation using an empowering and strength based focus versus negative reinforcement/consequences?

I think this shift will need to occur over a period of years and, of course, has actually already begun via training on things like stages of change and motivational interviewing. This transition will accelerate as we get better strengths-based assessment instrument and recovery planning instruments and protocol.

22. What evidence based practices are you familiar with that are effective in treating addiction?

There are several good registries of such practices and web sites (see http://www.samhsa.gov/ebpwebguide/appendixA_Across.asp; <http://www.nattc.org/resPubs/bpat/docs/Presentations/introebp.ppt#412,7,Evidence-Based Practices for Alcohol Treatment>; <http://www.nattc.org/resPubs/bpat/index.html>); And sites that provide manuals related to such practices (See www.bhrm.org and the adolescents treatment manuals posted at www.chestnut.org as samples.

23. Define and differentiate "recovery oriented care" and "reality of recovery"?

Recovery-oriented care is a term encompassing service designs whose elements are linked to intermediate and long-term recovery outcomes, e.g., therapeutic alliance, service dose, assertive linkage to communities of recovery, assertive approaches to post-treatment monitoring and support. Reality of recovery is a phrase most often use to call for a vanguard of recovering people and their families to step forward to offer themselves as living proof of the “reality of long-term recovery”—a social antidote to the “once a junkie, always a junkie” myth deeply buried in drug cultures and the culture at large.

"The general assumption is that, the greater the problem severity and complexity, the greater the restrictiveness and potential duration of treatment but comprehensive assessments of recovery capital can alter such decisions considerably"(p. 57)Please explain the term "Recovery Capital" and how it impacts the level of care.

24. Recovery management, how is that differ to a continuum of care?

Continuum of care is a treatment concept that delineates the beginning (identification, screening, assessment, intake, engagement), middle (service menu across multiple levels of care) and end (discharge planning, discharge and brief “aftercare”) of professional care. Recovery management is a broader conceptualization of the role of treatment in the long-term recovery process, e.g., destabilization of addiction, pre-recovery engagement, recovery initiation and stabilization, recovery maintenance and enhanced quality of personal/family life in long-term recovery. COC is measured in days, weeks, and (at best) months; RM is measured in years and focused on linking multiple interventions to shorten addiction careers and lengthen recovery careers.

25. At what point (if any) do we say no when we look at the term "revolving door"?

This is an agonizing question in the RM model. The critical question is this: Is our continued engagement of this client enhancing or inhibiting recovery initiation and maintenance? How would we know this? Measurable evidence toward recovery stabilization and success transitioning from recovery initiation to recovery maintenance, e.g., lapse/relapse episodes are decreasing in frequency, intensity, duration and consequences and periods of recovery are lengthening and characterized by growth in personal, family and social recovery capital. Another criteria: When the individual is readmitted, are they working on recovery or “doing time”—the latter renders treatment a milestone in one’s addiction career, not a milestone in a recovery career.

26. Can he give Long Island team concrete examples of how to create a peer support group for our recent and long term alumni? Based on his research, what does he recommend in terms of frequency of meetings?

Utilize a leadership development strategy that recruits indigenous leaders, engages a larger pool of clients/alumni via (focus groups, needs assessment processes, interests inventories). The purposes, activities, meeting frequencies, etc. should be defined by consumers/alumni and allowed to rapidly evolve over time as needed.

For an example of a long-term group, see

<p>Profile of a Vibrant & Enduring Recovery Alumni Association</p> <p>Group: Discovery (Alumni Association of New Day Center at Hinsdale Hospital, Hinsdale, IL) Founded: Early 1980s Founded by: John Daniels (aftercare director) and two graduates and their spouses. Membership Size: Ranged between 250-500 over past ten years Duration of Participation: 30-40% have participated for more than 5 years with some of founding members still participating Meeting Frequency: Monthly social events and 2-3 organizational meetings each year Social Event Activities: Potlucks, dinners out, bowling, weekend trips Average Event Attendance: 60-70 Distinctiveness / Keys to Success: Involvement of partners/spouses and children; development of long-term relationships with individuals/families in recovery; autonomy of group from treatment organization (New Day only provides space and assistance with mailings) Membership Fee: \$5 per person per year Association Assets: Approximately \$10,000 used to support activities and participation of any members who cannot afford activities. Greatest Challenge to Date: Engaging and retaining adolescents after treatment.</p> <p>Source: Interview with Don Malec, Discovery Leader, 630-240-1215.</p>

For info on early needs assessment process, contact Bev Haberle at Philadelphia’s Recovery Community Center 215-262-5771

Also see earlier profile of NET Consumer Council—one of best I have ever seen.

27. What resources or literature can he recommend for the family support group (non-professional) on recovery management?

Family-oriented models of RM are just developing. For a discussion of these and excerpts from family support group members, see White, W. & Savage, B. (2005). All in the family: Alcohol and other Drug Problems, Recovery, Advocacy. *Alcoholism Treatment Quarterly*, 23(4), 3-38. Posted at http://www.facesandvoicesofrecovery.org/resources/publications_white.php

28. Under the new model of recovery management, is it considered appropriate to maintain contact or initiate phone/email contact with clients who have completed treatment? In the past, this was taboo. For example, would setting up Yahoo group chat board (or something of the like) for alumni be within the realms of what is permissible and appropriate?

Yes and yes! But this is not at the whim of individual staff—such sustained contact is part of an established protocol and continued post-treatment contact with clients occurs within and only within this protocol. Shifting from an acute psychotherapy model to a model of long-term recovery support requires a rethinking of ethical boundaries in service relationships: compare this with the differences in definitions of appropriateness between emergency room nurses and hospice nurses or nurses doing home-based management of advanced diabetes. This does not mean that we throw everything away; but it means that we must redefine actions that are always okay, never okay and sometimes okay and sometimes not okay (and define the difference). (BTW, these definitions are often different by role, e.g., clinician versus recovery coach.) In the new world of RM, the latter category of sometimes is much larger, requiring a much greater emphasis on professional and peer supervision. Some of this is also just common sense—the recognition that in some cultural contexts greater harm can occur to multiple parties from refusing a gift than could occur from accepting that same gift.

See White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services. Posted At: http://www.facesandvoicesofrecovery.org/resources/publications_white.php

29. How are other traditional therapeutic community program adapting in the movement away from confrontation and humiliation and other iatrogenic practices and in the movement towards evidence-based practices?

David may be in a better position to answer this one than me. What I have done is focus on the history of such practices in the TC and the larger treatment world and collaborated with Bill Miller to interpret the scientific evidence on so-called “therapeutic confrontation.” (See White, W. & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, 8(4), 12-30.) I considered this article a form of amends to the field for my role in promoting confrontation as a therapeutic approach early in my clinical career.

Having been on the receiving and delivering ends of such confrontations and “learning experiences” since the late 1960s, here is how I make sense of this today. Confrontation was an essential tool in suppressing attitudes and behaviors that could corrupt a therapeutic milieu & may still serve this function. How do you suppress what we long called “dope fiend” behaviors in a community of addicts fresh off the streets? That requires mechanisms that can strip such behavior, inculcate new and extremely clear community norms, and enforce those norms on a

daily (and minute-to-minute) basis. I think confrontation was one of the tools that did this. But the larger question of whether such confrontation/humiliation actual has therapeutic properties is a quite different one, and the best evidence we have is that it has no such therapeutic effects and may be quite harmful, particularly with particular populations (See above citation for review of this literature).

I think we need to help the TC evolve as a whole by constructing its own recovery story that tells how it was, what happened that sparked change in key elements of TC practices, and what the TC is evolving toward today. David and I have talked a lot about the fact that “confrontation” involved many ingredients in the early TCs and took place in a particularly long-term relational context between individuals and between an individual and the TC family as a whole. The effects that we once attributed to the many forms in which confrontation occurred may have had more to do with the care, concern and acceptance that followed in the aftermath of such confrontations than in the act of verbal confrontation, shaving someone’s head or putting a sign or diaper on them. I would be interested in hearing from all of you about how you think TCs are evolving on this issue.

30. Other than the checklists from the Tools of Transformation website, what kind of strengths-based assessment would you recommend to do “intakes” and assess recovery “outcomes” in a voluntary recovery management/continuing care type program? Are there any “validated” instruments that are not pathology based?

The development of such instruments and protocol are part of an important national recovery research agenda, but some progress is being made. The Global Appraisal of Individual Need (GAIN) (See www.chestnut.org) now has some beginning measures of recovery capital built into them, and their were no less that 4 proposals to NIDA & NIAAA this past 6 months proposing the development of recovery-focused instruments. I have also been working on some simple recovery capital checklists that can be used as recovery planning tools. I will try to get these emailed for possible distribution to all of you.

THANKS EVERYONE FOR ALL THE WONDERFUL QUESTIONS! FEEL FREE TO EMAIL OR CALL IF YOU HAVE FOLLOW-UP QUESTIONS.