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Non-clinical Addiction Recovery Support Services: History, Rationale, Models, Potentials, and Pitfalls1

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Abstract

For more than 150 years, the transition from intractable addiction to stable recovery has often involved two quite different worlds: 1) professionally-directed addiction treatment aimed at biopsychosocial stabilization and recovery initiation, and 2) recovery mutual aid that has served as a medium of recovery initiation/stabilization and long-term recovery maintenance. A third sphere, nonclinical recovery support services, is rapidly emerging as a portal of entry into and a bridge between these two worlds. This article identifies factors related to the rapid growth of peer-based recovery support services, describes the organizational contexts in which they are being imbedded, outlines the variations in how the roles of recovery support specialists are being defined, and discusses the potentials and possible pitfalls of such services.

Key Words: Recovery support services, recovery coach, peer specialist, relapse prevention

Introduction

Peer-based (non-clinical) recovery support services (P-BRSS) are growing rapidly within the addictions arena. Six historically significant shifts constitute the soil from which P-BRSS are emerging: 1) the international growth and diversification of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004b), 2) the rise of a new grassroots addiction recovery advocacy movement in America (White, 2006a, 2007a , 3) recovery community building activities, e.g., recovery community organizations, recovery homes, recovery schools, recovery ministries/churches, recovery industries, and recovery community centers (Valentine, White, & Taylor, 2007: White, 2001c), 4) the emergence of recovery as an organizing paradigm within the addictions and mental health fields (White, 2005; Gagne, White, & Anthony, 2007; Davidson & White, 2007), 5) calls to extend the design of addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (McLellan,

Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002), and 6) growing interest in diverse 1 This article incorporates and updates material from White, W. (2004a). The history and future of peer-based addiction recovery support services. Presented at the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. 2 (religious, spiritual, secular, gender-specific, culturally-nuanced, and medication-assisted) pathways of recovery initiation and maintenance (White & Kurtz, 2006).

These trends have also sparked interest in recovery-related research and moved the concept of recovery to the center of federal and state behavioral health policy and programming initiatives. Examples of the latter include two Center for Substance Abuse Treatment initiatives--the Recovery Community Services Program (RCSP) and the Access to Recovery program (ATR)--that have collectively exerted considerable influence on the recent spread of P-BRSS. This article provides a brief overview of the history of P-BRSS, the rationale for such services, and the competing organizational contexts in which such services are arising. The article concludes with a brief discussion of potential pitfalls related to P-BRSS.

Historical Perspectives

Peer support for addiction recovery is rooted in the long and rich history of recovery mutual aid societies in America. This history spans 18th and 19th century Native American "recovery circles" (i.e., abstinence-based healing and religious/cultural revitalization movements), the Washingtonians (1840s), abstinence-based fraternal temperance societies (1840s-1870s), the Dashaway Association (1859), the Red Ribbon Reform Clubs (1874), the Drunkard's Club (1872), the United Order of Ex-Boozers (1914), Alcoholics Anonymous (AA) (1935), Narcotics Anonymous (1953), Twelve Step adjuncts (e.g., the Calix Society, JACS, International Doctors in AA), and innumerable Twelve-Step adaptations (related to other drug choices and other excessive behaviors). This history also

contains explicitly religious mutual aid alternatives to Twelve Step programs (e.g, Alcoholics Victorious, Alcoholics for Christ, Celebrate Recovery, Ladies Victorious, Free-N-One Recovery, Overcomers Outreach, and Millati Islami), secular recovery support alternatives (e.g., Women for Sobriety, Secular Organization for Sobriety, LifeRing Secular Recovery, and SMART Recovery®), as well as moderationbased alternatives (Moderation Management). Also noteworthy is the marked growth in culturally grounded addiction recovery support groups within Native American and African American communities (White, 1998, 2001a; Coyhis & White, 2002; Sanders, 2002).

The historical relationship between recovery mutual aid societies and professionally directed treatment institutions is a complex one. Recovery mutual aid societies have birthed treatment institutions as adjuncts to themselves. For example, the Dashaway Association founded the San Francisco Home for the Care of Inebriates. Recovery mutual aid societies have been birthed inside treatment institutions (e.g., founding of the Keeley Leagues by patients of the Keeley Institute). There is a long history of reciprocal referral of individuals between these two cultural institutions, as well as efforts by each to colonize the other (White, 1998).

Early peer-based social support linked to addiction treatment institutions include patient clubs developed within nineteenth century inebriate homes and asylums (Ollapod Club, the Godwin Association) and addiction cure institutes (Keeley Leagues)(1860s1890s), the Jacoby Club of the Emmanuel Clinic in Boston (1910), AA volunteers working within "AA wards" (of general hospitals), "AA farms" and "AA retreats"(1940s1950s), and peer-based supports linked to early halfway houses (1950s). Peer-based social support is more recently evident in self-managed recovery homes (e.g., Oxford Houses), California's "social model" programs, and the volunteer programs and alumni associations of addiction treatment programs (Jason, Davis, Ferrari, & Bishop, 2001; Borkman, Kaskutas, Room, et al, 1998). The latest surge in peer-

based recovery support services is emerging from new grassroots recovery community organizations (RCOs) and by treatment programs trying to extend their continuum of care (White, 1998, 2001a).

The use of paid peer helpers ("peer" defined here as people in addiction recovery hired to serve as guides for others seeking recovery) in the addictions arena also has a long history including recovered and recovering people working as temperance missionaries (1840s-1890s); aides ("jag bosses") and managers of inebriate homes (1860s-1900); Keeley Institute physicians (1890-1920); "friendly visitors" within the Emmanuel Clinic in Boston (1906); lay alcoholism psychotherapists (1912-1940s); managers of "AA farms" and "AA retreats" (1940s-1950s); halfway house managers (1950s); "paraprofessional" alcoholism counselors and professional "ex-addicts" (1960s1970s); credentialed addiction counselors; detox technicians, residential aids, outreach workers, and case managers (1970s-1990s); and, more recently, "recovery coaches," "recovery mentors," "recovery support specialists", "personal recovery assistants," and "peer specialists" (White, 1998, 2000a,b,c). Both paid and volunteer models of peerbased recovery support services are part of larger recovery-oriented system transformation efforts underway at the national (Clark, 2007), state (Kirk, 2007), and local (Evans, 2007) levels.

The Rationale for Peer-Based Recovery Support Services

The justification for peer-based recovery support services comes primarily from three sources. First, such services are a way to historically counter the over-professionalization, bureaucratization, and commercialization of addiction treatment as a social institution. P-BRSS are an attempt to reconnect addiction treatment to the larger and more enduring process of addiction recovery (Morgan, 1995; Else, 1999; White, 2000b), to move the locus of service activity from the treatment institution to the natural environments of those seeking help (White, 2001b), and to facilitate the shift from toxic drug dependencies and an unhealthy dependence on formal helping institutions to a "prodependence on peers" (Nealon-Woods et al., 1995). P-BRSS are also an attempt to humanize a system that, after decades of assault by reimbursement and regulatory authorities, is perceived by recovery advocates as more preoccupied with incomes than outcomes and more focused on the quality of service documentation than the quality of service relationships. Put simply, the service milieus of addiction treatment institutions have become less welcoming and engaging through their maturation. P-BRSS constitute one effort to re-elevate this engagement process. Parallel processes are underway in allied human service fields (Ungar, Manuel, Mealey et al., 2004).

The second rationale for P-BRSS is as a mechanism to correct flaws inherent in the dominant acute care model of addiction treatment. This medically-based model, characterized by a series of discrete activities (screen, assess, diagnose, treat, discharge, terminate service relationship) and directed by a professional over an ever-shortening period of time, is coming under rigorous criticism. Analyses of this acute care model of biopsychosocial stabilization find the system vulnerable in nine performance categories that have implications for P-BRSS (See White, Boyle & Loveland, 2002 for multiple study citations):

- attraction: Only a small percent of those needing services receive services and then do so primarily through external coercion.
- access: Innumerable obstacles inhibit access, and there is high attrition between help-seeking and first appointments.
- retention: Less than half of persons admitted to primary treatment successfully complete treatment.
- dose: A significant portion of addiction treatment clients receive less than the research-based treatment dose recommended by the National Institute on Drug Abuse.
- quality of services: Routine service elements within the acute care model lack scientific evidence of their effectiveness, and

some have been shown to do harm, i.e., confrontation.

• linkage to community recovery support resources: Linkage to recovery communities is mostly of a passive variety—verbal encouragement variety and is plagued by low connection and high drop-out rates.

• continuing care: Only a small percentage of individuals discharged from addiction treatment receive any significant post-treatment continuing care.

• post-treatment lapse and relapse rates: More than half of clients discharged will resume AOD use within 12 months.

• re-admission rates: More than 60% of those admitted to treatment already have prior treatment; nearly 20% have 5 or more prior treatment episodes.

Peer-based recovery support services focusing on pre-treatment engagement, in-treatment retention, assertive linkage to communities of recovery, post-treatment monitoring and sustained recovery coaching, and, when needed, early re-intervention constitute an effort to correct major system performance problems within the acute care model of addiction treatment.

The third rationale for P-BRSS draws upon two sources of literature. The first supports the value of peer-based services to those helped and to the helper—what Riesman (1965, 1990) christened the "helper principle." People who have overcome adversity can develop special sensitivities and skills in helping others experiencing the same adversity—a "wounded healer" tradition that has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements (Jackson, 2001). The second body of literature contains preliminary research suggesting the potential effectiveness of peer-facilitated models of change (Durlak, 1979; Hattie et al., 1984; Riessman, 1990), particularly within the arena of addiction recovery (Connett, 1980; Galanter et al., 1987; Blum & Roman, 1985). These models include both peer-based recovery support societies and peer-based adjuncts to traditional addiction treatment.

The potential of peer-based models of recovery support has not been subjected to focused and sustained research, but the potential of P-BRSS services in long-term addiction recovery is suggested in study findings that reveal:

• The achievement of stable recovery from addiction can span decades and multiple episodes of treatment (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Hristova, 2002). P-BRSS may provide a mechanism for shortening addiction careers and lengthening recovery careers.

• Addiction recovery begins prior to the cessation of drug use and is marked by extreme ambivalence that continues well beyond the stabilization of sobriety (White & Kurtz, 2006). P-BRSS constitute a resource to manage that ambivalence and achieve a stable stage of recovery maintenance.

• Linkage to recovery mutual aid groups and physical and social environments conducive to recovery can enhance long-term recovery outcomes (Humphreys, Moos, & Cohen, 1997; Fiorentine & Hillhouse, 2000; Timko, Moos, Finney et al., 1999; Morgenstern, Labouvie, McCray et al., 1997; Kaskutas, Ammon, & Wesiner, 2004; Jason, Davis, Ferrari, & Bishop, 2001). P-BRSS constitute a mechanism of assertive linkage to such resources.

• A personal "guide" can help facilitate disengagement from the culture of addiction and entrance into and engagement with a culture of recovery (White, 1996). Those providing P-BRSS serve as such guides.

• The achievement of stable recovery is influenced by recovery capital—the internal and external assets available to initiate and sustain recovery (Granfield & Cloud, 1999). The development of recovery capital is a primary focus of PBRSS.

• Addiction treatment outcomes are enhanced by the provision of ancillary medical, psychiatric, and social services (McLellan, Arndt, Metzger et al., 1993; McLellan, Hagan, Levine et al., 1998; McLellan, Hagan, Levine, Meyers et al., 1999). PBRSS may provide an effective source of linkage to such services.

• The point at which most recoveries become fully stabilized is between four and five years after recovery initiation (Vaillant, 1996; Jin, Rourke, Patterson, Taylor, & Grant, 1998), suggesting the need for sustained monitoring and support that could potentially be provided by P-BRSS.

• Preliminary studies of assertive models of post-treatment "recovery checkups" for adults (Dennis, Scott, & Funk, 2003) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002) suggest such sustained support can enhance long-term recovery outcomes and can be delivered in face-to-face, telephone-based, or Internet-based formats (McKay, 2005; McKay, Lynch, Shepard, & Pettinati, 2005; Kurtz & White, 2007).

The P-BRSS Role

The range of services provided within the framework of P-BRSS is indicated by the broad range of roles the recovery coach is expected to perform. In earlier publications (White, 2004c, 2006b), I have described the multiple roles of the recovery coach (See Table One).

Table One: Roles of the Recovery Coach

Motivator and cheerleader: exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement.

Ally and confidant: genuinely cares, listens, and can be trusted with confidences. Truth-teller: provides a consistent source of honest feedback regarding selfdestructive patterns of thinking, feeling and acting.

Role model and mentor: offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice.

Problem solver: identifies and helps resolve personal and environmental obstacles to recovery.

Resource broker: links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support.

Advocate: helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights.

Community organizer: helps develop and expand available recovery support resources.

Lifestyle consultant: assists individuals/families to develop sobriety-based rituals of daily living.

A friend: provides companionship.

Also noted were the functions the recovery coach was not expected to serve. The recovery coach is NOT a sponsor (does not perform AA/NA service work on "paid time"), a therapist (does not diagnose or probe undisclosed trauma/"issues"; does not refer to their support activities as "counseling" or "therapy"), a nurse/physician (does not make medical diagnoses or offer medical advice), or a priest/cleric (does not respond to questions of religious doctrine nor proselytize a particular religion/church).

The verbs most frequently used to describe the activities of the recovery coach include engage, elicit, validate, share, express, enhance, orient, help, identify, link, consult, monitor, transport, praise, enlist, encourage, and support. The fact that P-BRSS specialists fulfill all these roles and functions is both a strength and vulnerability of PBRSS models.

Persons providing P-BRSS, rather than being legitimized through traditionally acquired education credentials, tend to be legitimized based on experiential knowledge and experiential expertise (Borkman, 1976).

"It is not the experience of having been wounded or having transcended such wounds that constitutes a credential. It is the extraction of lessons from that experience that can aid others, and a new ethic that transforms that learning into service to others. Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. Experiential expertise requires the ability to use this knowledge to affect sustainable change in self or others. It requires the ability to separate the experience of the helper from that of the person being helped. The dual credentials of experiential knowledge and experiential expertise are granted through the addiction/recovery community "wire"/"grapevine" via storytelling. It is bestowed only on those who offer 2 P-BRSS specialists draw from an eclectic menu of religious and secular concepts and metaphors to anchor the recovery process. 7 sustained living proof of their expertise as a recovery guide within the life of the community (White & Sanders, in press)."

P-BRSS services are best delivered within the recognition of multiple long-term pathways of recovery (White, 1996). The practical implications of this proposition is that the recovery support specialist must acknowledge the legitimacy of these multiple pathways; become conversant with the language, catalytic metaphors, and rituals reflected within these pathways; work to expand the variety of recovery support structures within the communities he or she serves; and develop relationships with the myriad groups representing these pathways. The best P-BRSS also recognize multiple styles of recovery. Such style variations are reflected in the recovery initiation process (transformative change versus incremental change), identity reconstruction (recoverypositive, recovery-neutral and recovery negative identities), and post-

recovery interpersonal relationships (acultural, bicultural and culturally enmeshed styles of recovery) (White & Kurtz, 2006). The operational motto of the best P-BRSS specialists is "recovery by any means necessary." It matters little to them whether recovery is initiated without professional assistance (solo or natural recovery), with peer-assistance or professional treatment (affiliated or assisted recovery), or is initiated via peer and professional supports but maintained without such assistance (disengaged recovery) (White & Kurtz, 2006). The focus is on the singular goal of recovery, not a particular method. Such tolerance and respect requires maturity and wisdom.

P-BRSS Models

The definition of the recovery coach role is shaped heavily by the organizational context in which these services are offered. There are currently at least three different contexts through which P-BRSS are being delivered, each of which influences the character of the P-BRSS role and the services offered.

In the medical/clinical model of P-BRSS service delivery, the recovery coach is often a trained professional (most commonly a certified addictions counselor) employed by an addiction treatment institution who is expected to provide recovery coaching responsibilities in addition to other service roles within the organization. For example, an addictions counselor in a residential program may be asked to provide post-treatment telephone-based recovery coaching to clients for whom he or she earlier served as a primary counselor. A variation of this model is the hiring of peer specialists (without professional credentials) to deliver pre-treatment, in-treatment, or post-treatment recovery support services. Within the medical/clinical model, P-BRSS are defined as another "level of care" within the continuum of clinical services and thus have a distinctly clinical orientation. The strength of this model is the potential continuity of support provided to clients before, during, and following addiction treatment. The weaknesses of this model

are that the "peer" is often not really a peer and the tendency in these settings is to turn the recovery coach into a junior therapist by defining the role via the professional ethics, and activities that govern clinical roles in the organization. 3 Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite change in beliefs, behavior, identity, and relationships. 4 Transformative change is characterized by its suddenness, vividness, positiveness, and permanence (Miller & C'de Baca, 2001).

In the P-BRSS community development model, the recovery coach is usually a person in recovery who has been "vetted" via his or her service history within a local community of recovery. In this model, the recovery coach works for a recovery community organization that most often provides three types of services: recovery advocacy, recovery education, and peer-based recovery support services. In this model, P-BRSS are viewed within a framework of community development and cultural revitalization (White, 2003, 2007b), and the agent of healing is viewed not as the recovery coach but the community itself. The recovery coach's role in this model is to help build recovery support resources in the local community and to link individuals and families to such resources. This model may use paid or volunteer recovery support services or a combination of paid and volunteer roles. The strengths of this model include its capitalization on knowledge of indigenous addiction and recovery cultures, its close connections to natural recovery support resources, and its capacity for a long-term recovery support alliances. One weakness of this model is that advocacy activities can take the recovery coach and the recovery community organization into institutional conflicts that can interfere with services to individuals and families.

In the P-BRSS business model, the services of a recovery coach are offered by an independent for-profit agent. Recovery coaching is being delivered as a private practice service offered mostly by people who have backgrounds in addiction treatment or intervention services. Coaches in these settings offer a varying intensity of services that can include 24-hour supervision and support during the first weeks following an individual's discharge from addiction treatment. Some recovery coach businesses charge up to $800 a day for recovery coaching and cater to people being discharged from "spa/boutique" treatment settings. The near invisibility of these organizations and the lack of any scientific studies of such private services make further description of this model impossible. Perception of private recovery coach agencies communicated to the author by recovery advocates from around the country range from seeing them as offering a valuable service to those who can afford it to allegations that they are institutional predators who view the relapsing alcoholic and addict as a crop to be harvested for financial profit.

There are substantial barriers to implementing any of the above P-BRSS models. Some of these challenges are conceptual (e.g., failure to see the need for P-BRSS services); disagreements over the definition of "peer"; and conflicts between the P-BRSS emphasis on recovery community building and traditional biopsychological models of problem intervention. Emotional challenges include the failure of traditionally-trained professionals to accept P-BRSS service specialists as legitimate professional peers. Technical and administrative barriers include the lack of empirical models of P-BRSS, the lack of P-BRSS implementation protocols, and challenges complying with treatmentoriented licensing and reporting procedures. Substantial financial barriers also exist, including the lack of financing models for P-BRSS and local and state fiscal austerity that limits new service initiatives.

One of the most critical questions related to P-BRSS is how such services fit within or are connected to the existing addiction treatment continuum of care. There is the possibility that P-BRSS will evolve as a separate system disconnected from the national network of addiction treatment programs. P-BRSS are coming out of a new generation of grassroots recovery advocacy and support organizations that perceive many treatment programs as too preoccupied with their own institutional interests. This

undercurrent of disenchantment and hostility and its sources will need to be openly confronted and resolved if the goal of a system of integrated clinical and recovery support services is to be achieved. Lacking such resolution, the proliferation of P-BRSS and their alienation from mainstream treatment could further fragment a system that is already difficult to navigate.

There is a real question about the best organizational location for recovery support services. The answer to that question will require guidance from community elders, feedback from service consumers, a cost comparison of various models, and research studies to determine if recovery outcomes are enhanced when they are linked to particular types of P-BRSS service delivery sites. As this process unfolds over the next few years, the following principles are suggested as a foundation for interim collaboration.

- P-BRSS and professionally-directed addiction treatment services are complimentary rather than competitive.
- P-BRSS and treatment services should be integrated into a single, seamless continuum of services (regardless of the settings out of which they are delivered).
- P-BRSS specialists and treatment specialists must recognize and respect the special contributions each can make to the recovery process.
- Both P-BRSS specialists and treatment specialists must accurately represent and practice within the boundaries of their education, training, and experience.

The goal is to have all services—professional and peer—become person-oriented, family-oriented, and recovery-focused.

Strengths and Vulnerabilities of P-BRSS

P-BRSS services will require extensive evaluation to determine their effects on addiction and recovery careers. There is particular interest in how P-BRSS can potentially enhance the effectiveness of the existing treatment system. Testing the following hypotheses would be a good

starting point for such research. P-BRSS services are predicted to:

- increase the number of people entering addiction treatment,
- decrease the number of people "lost" from waiting lists to enter addiction treatment,
- divert individuals with lower problem severity and higher recovery capital into natural recovery support systems in the community (creating a better stewardship of limited treatment resources),
- enhance treatment retention and completion,
- increase post-treatment abstinence outcomes,
- delay the time period from discharge to first use following treatment (enhancing development of recovery capital),
- prevent lapses from becoming relapses,
- shorten the number, intensity, and duration of relapse episodes following treatment,
- decrease treatment readmission rates (slow the revolving door of treatment),
- decrease the time between relapse and re-initiation of treatment and recovery support services (preserving recovery capital and minimizing personal and social injury),
- result in readmission to less intensive, expensive levels of care,
- reduce attrition in first year affiliation rates with AA and other sobriety-based support groups, and
- enhance recovery capital (e.g., employment, school enrollment, stable housing, healthy family and extended family involvement, sobriety-based hobbies, financial resources) and self-defined quality of life.

At a systems level, P-BRSS offer an opportunity to enhance linkages between the existing treatment agencies and local indigenous recovery support systems; linkages that have eroded due to the regulation and commercialization of addiction treatment. P-BRSS roles may also offer an opportunity to retrieve the best of what was lost on the road to professionalizing the role of addiction counselor; that is, a service relationship based on moral equality, practical

recovery coaching, knowledge of and active linkage to local communities of recovery (White, 2004c).

The strengths and vulnerabilities of P-BRSS are integrally connected. The values of accessibility and working within natural environments have a shadow side of overextension, burn-out and concerns about the physical and psychological safety of P-BRSS specialists. The reciprocal, non-hierarchical nature of the P-BRSS relationship leaves open the danger of boundary violations and abuses of power. The emphasis on continuity of support over time leaves agencies providing P-BRSS struggling to define their recovery support capacity (e.g., how many people can be supported in what manner for how long?). The value of client empowerment and the rebellion against the growing coerciveness of addiction treatment run headlong into dilemmas of how to respond when those we serve pose threats to others. The grassroots P-BRSS movement will need to actively manage the inevitable pull towards specialization, professionalization, and commercialization. Confronting ineffective practices in the existing treatment system, including those within agencies that are experimenting with P-BRSS, and being viewed as competition for scarce funding resources will also align the P-BRSS movement against powerful institutional and professional interests.

The P-BRSS movement also will need to confront how addiction-related stigma can distort its own operations as an organization or organizational unit, potentially leading to "incestuous closure," ideological schisms, the scapegoating of organizational/unit leaders and members, the exploitation of organizational/unit members, and organizational/unit stagnation and implosion (See White, 1997; Janzen, 2001).

Potential Iatrogenic Effects of P-BRSS

The history of addiction treatment is filled with iatrogenic insults (i.e., treatment-caused harm or injury) (White, 1998), and the potential for such effects with P-BRSS requires active prevention and management.

Risk to Service Consumers: Consumers of recovery support services could be injured from incompetent care and through boundary violations (e.g., financial, emotional, and sexual exploitation) in their relationships with P-BRSS service specialists. P-BRSS may require a set of protections analogous to those provided upon entry to addiction treatment (e.g., credentialing, codified ethical standards, complaint procedures, informed consent, confidentiality, clinical supervision), but such mechanisms must be crafted in consultation with consumers and local communities of recovery. Minor adaptations of existing clinically-oriented standards and support procedures would NOT constitute effective protections for the P-BRSS provider or consumer. Efforts are currently underway to develop ethical guidelines for P-BRSS (White, The PRO-ACT Ethics Committee, Popovits, & Donohue, 2007).

Risk to P-BRSS Providers: There are several potential risks to the providers of PBRSS, including vulnerability of exploitation (e.g., excessive hours, low pay/benefits/status, abuses of power in the relationships between P-BRSS specialists and professionals), alienation/isolation from the recovery community, vulnerability of relapse, particularly in organizations or work environments not conducive to personal recovery. Such exploitation and vulnerability of recovering people working in service roles is a hidden story within the rise of modern addiction treatment (Wilson, 1984; White, 1979, 1998).

Risk to P-BRSS Service Organizations: Service organizations will face liability risks related to improper hiring, supervision, and retention of P-BRSS workers who are involved in illegal or unethical conduct. Such liability will need to be actively managed via rigorous screening and hiring procedures, rigorous training and supervision, and the development of clear ethical guidelines governing the delivery of P-BRSS.

Risk to the Community: P-BRSS could also injure the larger recovery community by engendering conflict about such services within mutual aid organizations and by undermining or commercializing the service ethic within

such organizations. The goal of P-BRSS services is to exponentially expand natural recovery support services within each community, not replace voluntary support services with paid services. If the result of PBRSS services is the latter, the harm will be a significant one (McKnight, 1995).

Closing Reflection

The current acute care model of addiction treatment is in need of redesign and renewal. P-BRSS could become a superficial (i.e., token) appendage to this broken system, or it could become a catalyst for recovery-focused system transformation. PBRSS could help shift the addiction treatment system from serial episodes of encapsulated acute care to a model of sustained recovery management. So typical of the many paradoxes of recovery, addiction treatment as a system of care might well be redeemed by those for whom it was originally designed to serve. On the other hand, if PBRSS are over-professionalized and commercialized into an ever-growing and overextended recovery support services industrial complex and if that paid support erodes the service ethic within local communities of recovery, then the experiment with P-BRSS will have failed horribly.

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