

The Role of Community in Addiction Recovery

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

Addiction treatment in the modern era has been practiced as an essentially biopsychological intervention. Its central activities have often focused on sequestering the addicted individual from his or her family and cultural environment and attempting to alter the biological states and psychological attributes believed to constitute the etiological roots of alcohol and other drug (AOD) problems. Socio-cultural models of intervening with AOD problems at a personal level have existed in recent decades at the periphery of the treatment field (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998), or have arisen as religious or social movements outside the professional world of addiction treatment (Williams & Laird, 1992).

This near-exclusive focus on the vulnerabilities and resiliencies of the individual has not always dominated the AOD problems arena. There are episodes in the history of addiction treatment and recovery in which one finds a much greater emphasis on the ecology of addiction and recovery. Such episodes reflect models of community resource development and mobilization that could serve as alternatives and adjuncts to today's clinical models of intervention.

This chapter explores the power of community within the processes of addiction recovery. Our intent is not to impugn models of understanding and resolving alcohol and other drug (AOD) problems that focus primarily upon biological or psychological vulnerabilities. It is rather to offer a reminder that these dimensions of vulnerability and methods of intervention exist within particular physical, family and cultural environments that exert their own profound influence on the vulnerability for addiction and the potential for recovery. We will contend that: 1) the health of individuals, families and communities are inseparable, 2) communities constitute an underutilized resource of recovery support, and that 3) professionalized system of intervention into AOD problems need to be closely linked to indigenous systems of support within local communities where such support exists, and organized and mobilized where it does not exist. We will talk about "community" at multiple and overlapping levels: family, kinship and social networks; neighborhood- and local community-based cultures of addiction and recovery (the physical and cultural environments within

which addiction and recovery are initiated and sustained); local communities and their institutional economies (from illegal markets to local service institutions) and the macro-culture of attitudes and values that shape the prevalence and character of addiction and recovery.

Recovery, Community, History

We begin this exploration with a brief discussion of the role of community in addiction recovery as viewed within critical periods in the history of addiction recovery mutual aid societies and addiction treatment institutions. Addiction recovery mutual aid societies have existed in America for more than 200 years (Humphreys, 2004, White, 2004b). Contrasting views of the role of community and recovery are illustrated in a comparison of Native Americana and Euro-American recovery support structures.

Abstinence-based religious and cultural revitalization movements in Native America from the Delaware Prophets, Handsome Lake, the Shawnee Prophet, the Kickapoo Prophet, and the Native American and Indian Shaker Churches through the contemporary Red Road and Wellbriety movements) have portrayed colonization and cultural decay as a root of addiction, and cultural and community renewal as its most potent antidote. In this view, colonization and oppression, the destruction of cultural history and traditions, lost tribal identity and cohesion, and the resulting disintegration of family constitute the essential etiological agents in the rise of alcohol and other drug problems in Native American. The resolution of alcohol and other drug problems at an individual level are seen as inseparable from the repair and renewal of the family and the tribe (Coyhis and White, 2003; Coyhis, White and Simonelli, forthcoming). This broader view of the sources and solutions to AOD problems has continued within American communities of color (White and Sanders, 2004).

In contrast, recovery movements within Euro-American communities have lacked this ecological perspective on the sources of alcohol and other drug problems, but have conveyed the importance of community in recovery. From the Washingtonians through Alcoholics Anonymous and its adjuncts and alternatives, there have been two consistent messages: 1) recovery involves a reconstruction of personal identity and interpersonal relationships, and 2) this personal and interpersonal transformation is best achieved in relationship to a community of recovering people.

Disagreements about the role of community in recovery were common among the founders of America's first addiction treatment institutions. Those who

pioneered nineteenth century inebriate asylums viewed the family and community as an enemy of recovery; advocated prolonged, legally enforced sequestration of addicts from community life; and discouraged contact between addicts and their families and social networks during treatment. In contrast, inebriate homes and the religiously-oriented urban missions and rural inebriate colonies sought to immerse those seeking recovery in a community of shared commitment and reciprocal support. The private addiction cure institutes similarly encouraged their patients to fully participate in community life during treatment and to participate in institutional support groups (e.g., the Keeley Leagues) upon their return home (White, 1998; White and Savage, 2003).

The rise of modern addiction treatment was marked by a polarization of thinking about community and recovery. The 1960s and 1970s saw two competing paradigms. The winning paradigm defined AOD problems as a biopsychological phenomenon: a diagnosable medical disorder requiring professional intervention. Such interventions focused on reversing the individual's physical adaptations to the drug (withdrawal, craving) and altering addiction-related patterns of thinking, feeling and behaving. The approach emphasized case-finding, clinical screening and assessment, medical and psychological treatment of the individual, and brief aftercare services--all provided by clinically trained professionals. This individualized conception of AOD problems and their solution provided the foundation for the legitimization and industrialization of modern addiction treatment in America. The biopsychological model became so dominant that there is only fading memory of its alternative.

During the 1960s and early 1970s, an alternative to the clinical model of addiction treatment was pioneered within several states and within the alcoholism programs of the federal Office of Economic Opportunity (OEO). This model focused on building capacity to address alcohol problems not within a treatment center but within the larger community. Counselors in this model were trained in community development skills with an emphasis on using indigenous recovery support structures such as Alcoholics Anonymous rather than trained in clinical skills (NAADAC..., 1992). What was most distinctive within OEO was the belief that alcoholism programs had to be built on the needs of, and ultimately controlled by, alcoholics and their families (Renaud, 1982). The OEO and selected state programs sought to do two things: 1) undermine the forces in the community that contributed to AOD problems, and 2) create space within the community where recovery could flourish.

Harold Mulford extensively documented the philosophy of this early model in Iowa. The role that was at the center of the Iowa model was not a counselor,

but a “Community Alcoholism Agent” (CAA) who served as a case-finder, motivator, educator, advisor and friend to the alcoholic and an educator and resource mobilizer in the community. The goal was to get as many people as possible involved in the alcoholic’s recovery (Mulford, 1976). This model, which relied to a great extent on volunteer support, fell out of favor in the 1970s amidst calls to address alcohol problems with greater organization, skill, and financial resources. In that rising tide of professionalization, voluntarism within the addiction problem arena declined and was replaced by an ever-growing class of paid helpers whose focus shifted from the community to the clinic and the intrapersonal experiences of those with AOD problems.

It can be seen from this brief review that these lay recovery movements and professional treatment movements had diverse views about whether addiction recovery was something that emerged from within the self, was something that was done to the addicted individual by treatment professionals, or something that was experienced in the context of the addict’s relationship with a recovering community. The pendulum of emphasis in addiction treatment is currently shifting from a focus on the individual to a rediscovery of the community environment. This shift is evident in calls to: 1) transform the clinical model of addiction treatment into more community-focused “recovery-oriented system of care” (see DMHAS, 2004), 2) shift addiction treatment from an institution-based model of acute intervention to a community-based model of sustained “recovery management” (White, Boyle and Loveland, 2003), and 3) growing interest in peer-based recovery support services (White, 2004a). This heightened interest in the role of community in recovery is further evident in President Bush’s recently announced Access to Recovery program and the expansion of the Center for Substance Abuse Treatment’s Recovery Community Support Program.

The Ecology of Recovery: Key Principles

There are several key principles and observations that are emerging in this renewed exploration of community as a catalyst and support for addiction recovery. In this section, we will briefly discuss some of these propositions.

Changing Community Context *Growing numbers of individuals are experiencing social disconnection, isolation and a loss of social identity and life-shaping social norms.* This alienation and anomie is the product of escalating changes in nuclear family structure; decreased quantity and quality of contact with extended family and kinship networks; the loss of socially intimate, value-homogenous neighborhoods; and weakening attachment to primary social

institutions, e.g., schools, workplaces, churches (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). In the face of these changes, there are calls for “community building”—creating or strengthening healing environments--as a strategy for resolving a wide variety of personal problems (Jason & Kobayashi, 1995). The surging interest in family and community within the addictions field reflects more global preoccupations with the health and healing potential of families and communities. *Existing institutions are being transformed and new social structures are emerging to perform what have historically been family functions.* Schools, workplaces, and social agencies have all absorbed a growing list of functions once performed by family members and extended family members. Alternative social structures from gangs to self-help groups are also taking over functions historically performed by families.

Community as an Etiological Agent *The experience of community can be pathogenic (wounding, deforming) or salugenic (healing, wholeness-generating).* When community infrastructures decay, there are widening physical, psychological and social spaces where sickness can rapidly spread. Coyhis (1999) has referred to such spaces as the diseased soil of community life. *Cultures of addiction, with their own history, traditions, language, values, and rituals flourish in wounded communities* (White, 1996). These cultures meet a wide variety of needs of individuals disaffiliated from families and mainstream social institutions. People can become as dependent upon these cultures (and the identity and affiliation needs met there) as upon the drugs that are the central sacraments of these cultures. *Within besieged communities, personal sobriety and survival may be inseparable from the sobriety and survival of the larger community.* In such communities, the individual draws nourishment from a healthy community just as the sobriety and service of the individual feeds that community. Where the addiction of individuals constitutes a manifestation of the wounds of a larger community, both the individuals and the community require treatment (Brave Heart, 2003). There are vibrant examples of such simultaneous personal recovery and community revitalization (see Williams and Laird, 1992).

Community as an Obstacle to Recovery *Communities can pose specific obstacles to addiction recovery by failing to provide the physical, psychological and social space where recovery can be initiated and by failing to provide escape routes into that alternative world.* Escalating pain precipitates recovery initiation only in the presence of hope, and that hope often springs from resources and relationships outside the self. Communities constitute an obstacle to recovery as long as they allow cultures of addiction to flourish, provide no visible role models for long-term recovery, and provide no visible pathways to recovery.

Limitations of Biopsychological Treatment While many people's lives have been transformed by addiction treatment, such treatment as currently delivered is limited in what it can achieve. Even with the coercive influence of multiple systems, addiction treatment is able to attract only ten percent of persons in need of such services (SAMHSA, 2003). The current system relies almost completely on the pain of natural consequences to bring those with AOD problems into treatment. If we were really serious about treating addiction, we would send teams of recovery messengers/recruiters into the very heart of local drug cultures. Less than half of those admitted to addiction treatment successfully complete treatment (SAMHSA, 2002), and there is no system of post-treatment monitoring and early re-intervention for non-completers. Many of those completing treatment receive less than the optimal dose of treatment prescribed by the National Institute on Drug Abuse (1999). Post-treatment continuing care services enhance recovery outcomes, but only 20% of clients discharged from addiction treatment receive any significant dose of such services (McKay, 2001). Similarly, post-treatment mutual aid society participation enhances long-term recovery outcomes, but there is high attrition in such participation following treatment (Mäkelä, Arminen, Bloomfield, Eisenbach-Stangl, Bergmark, Kurube, et al., 1996). There are high rates of post-treatment relapse and re-admission. Sixty percent of persons admitted to addiction treatment in the U.S. already have one or more prior episodes of treatment (SAMHSA, 2002). *Without community supports to engage people at an early stage of problem development, enhance treatment completion, link people to indigenous recovery support systems and provide post-treatment monitoring and early re-intervention, addiction treatment in the United States will continue to operate as an emergency room whose cyclical episodes of biopsychological stabilization will fail to generate long-term recovery in the community for the majority of people with severe AOD problems.*

Coyhis (1999) suggests that temporarily transplanting sick trees, nurturing them back to health and then replanting them in the original diseased soil from which they were removed makes little sense. He argues that we must treat the wounded individuals and the diseased soil of community life by treating the community as well as its members—by creating a healing forest. It is in this way that the community becomes simultaneously a recipient of treatment and an instrument of recovery initiation and maintenance.

Isolation of Treatment from Community *The greater the physical and cultural distance between the treatment center and the natural environment of the person being treated, the less the transfer of learning from the former to the latter.*

Prolonged sequestration of people with AOD problems in the name of treatment

injures those being treated (by rooting their recovery to an institution rather than to a natural network of relationships in the community), injures treatment agencies (by promoting closed, incestuous systems prone to implosion, e.g., Synanon), and injures the community by failing to develop natural recovery support systems that are sustainable and non-commercialized.

Recovery Stability/Durability and Community *Professional support for recovery from addiction should be sustained until the individual/family recovery process can be sustained on its own momentum in the individual/family's natural community.* The period of recovery durability (the point at which future risk of relapse in one's lifetime drops below 15%) following treatment for alcoholism is reached between 4-5 years of sustained recovery (Jin, Rourke, Patterson, Taylor, & Grant, 1998)--longer for recovery from opiate addiction (Hser, Hoffman, Grella, & Anglin, 2001). Building systems of support for recovery maintenance will require creating connecting tissue between treatment institutions and the community environments in which their clients live. We are not proposing that primary treatment be sustained indefinitely, but we are suggesting the utility of assertive continuing care in the community, e.g., post-treatment monitoring and support, stage-appropriate recovery education, active linkage to local communities of recovery, recovery community resource development and early re-intervention. Such sustained recovery support services could transition from a level of high intensity during the first 90 days following primary treatment (the period of highest risk for post-treatment relapse) to low intensity but sustained monitoring, e.g., recovery checkups (See Dennis, Scott, & Funk, 2003) as recovery supports shift from the institutional environment to the community environment.

Community as an Agent of Healing Like addiction, recovery is mediated by processes of social engagement and support (See McCrady, 2004 for an excellent review). *Cultures (communities) of recovery, with their own history, traditions, language, values, and rituals flourish in communities that welcome them* (White, 1996). There is no single "recovery community," but a growing diversity of "communities of recovery" that differ significantly in their membership characteristics and in their philosophies and support technologies (Kurtz & Kurtz, 2004). The primary purpose of these micro-communities (communities within a community) is to support individuals and families through the developmental stages of addiction recovery. Within these communities of recovery, people with severe AOD problems experience a sense of being at home--of being at the one place where one's absence would be missed. Communities of recovery are places of sanctuary and healing for those who have been stigmatized and marginalized by their addiction careers. There one is accepted not in spite of one's imperfectness,

but because of the very nature of that imperfection. Communities of recovery are places of refuge, refreshment and renewal, whether they exist in the meeting rooms of churches or in the virtual world of the Internet. For many people, recovery from addiction is a journey between two physical and social worlds—a movement from the toxic world of drug dependency to a healthy “prodependency on peers” (Nealon-Woods, Farrari and Jason, 1995). *Strategies that enhance family and community cohesion and nurture the development of healing networks within the larger community may serve to prevent AOD problems as well as facilitate problem identification and resolution.*

Styles of Recovery Affiliation Not all people in recovery relate to these communities of recovery in the same way. There are *acultural styles* of addiction/recovery (no affiliation with other addicted/recovering people), *bicultural styles* of recovery (balanced association with an addiction/recovery community and the larger community), and *enmeshed styles* of recovery (immersion in a culture of addiction/recovery with little contact with civilians—persons without addiction/recovery experience). *Persons with an enmeshed style of addiction often require an enmeshed style of recovery initiation* (White, 1996). Discharging clients from addiction treatment into drug-saturated family and social environments is a recipe for relapse. What is called for is the development of strong local cultures of recovery that can compete with, insinuate their way into, and eventually transform these toxic environments.

Potential Iatrogenic Effect of Social Interventions *Professional interventions into health and social problems may through their design either weaken or strengthen the community’s natural capacity for support.* John McKnight (1985) argues that the proliferation of helping agencies over the past half century generated the unintended effect of undermining and hastening the dissolution of traditional support provided by families, extended families, neighborhoods, churches, labor unions, and whole communities. He contends that as a country we suffer, not from a lack of professionally-directed service agencies, but from a lack of community. To the extent that responsibility for caring for those with the most severe AOD problems passed from families and indigenous community institutions (schools, churches, voluntary mutual aid groups) addiction treatment professionals, the treatment field may have inadvertently contributed to the abandonment of these individuals by the community. There is a growing population of addiction treatment recidivists who are estranged from family, friends and community, who are not accepted members of local communities of recovery, and who seem to be trapped within the limbo world of addiction treatment. It is time we helped with their reintegration or built alternative

communities to support their recoveries.

Community Building and the Community Guide McKnight (1995) advocates the creation of “community guides” who move wounded citizens, not toward enmeshment with professional helpers and their institutions, but toward deeper involvement in the problem-solving and healing resources within the larger community. *The goal of community building is to replace, to the greatest extent possible, relationships that are transient, hierarchical, and professionalized with relationships that are enduring, equal, and reciprocal.* The goal is to support long term recovery by nesting this recovery in communities defined not by geography but by shared experience, shared identity, shared need, shared hope, and shared support.

Strategies for Community Building *The field of addiction treatment can tap the healing power of communities of recovery by focusing on six zones of activity.*

- *Knowledge Development:* enhancing the treatment organization’s understanding of the growing diversity of American communities of recovery by involving professional staff within the life of these communities.
- *Role Redefinition:* including the function of recovery community resource development and mobilization.
- *Community Involvement:* increasing collaboration with indigenous sobriety-based support structures and other indigenous healers/institutions.
- *Recovery Resource Development:* playing an active role in the development of local recovery support groups and recovery support services.
- *Consumer Involvement:* Involving recovering people and their family members in the planning, design, delivery, and evaluation of treatment services.
- *Identity Reconstruction:* Exploring the implications of this new community partnership on the treatment organization’s mission, core values, service menu, service roles, and the ethical standards governing relationships between staff and service consumers (White, 2002).

Peer-based Recovery Support Services (P-BRSS) There are a growing number experiments with peer-based recovery support services as an adjunct and alternative to addiction treatment. The roles—both paid and voluntary--that are at the center of these service models go by varied names: recovery coach, recovery

mentor, peer counselor, recovery support specialist. Some states (CT, AZ) are systematically including P-BRSS as part of a reconfigured continuum of addiction treatment services care, and at least one state (PA) is already investigating the credentialing of recovery support specialists. What these experiments share in common is the use of P-BRSS specialists to reconnect treatment to the larger and more enduring process of recovery and to build connecting tissue between the service recipients, the treatment institution, local communities of recovery and the larger community in which the processes of recovery must be anchored (White, 2004a).

Potential Pitfalls

This proposed integration of clinical and community development models is not without its pitfalls. The functions require fundamentally different skills than the skills required for clinical roles and may be best delivered out of different organizational contexts. There are no existing funding streams to support recovery community resource development and the advocacy activities that are often implicit in such resource development. There exists a danger that the natural service ethic within communities of recovery will be weakened by the likely professionalization of recovery support services. The ethical guidelines for clinical roles will not easily transfer to recovery support and community organization activities, and there are few alternative guidelines for the management of ethical dilemmas within non-clinical activities. At a broader level, the community's capacity for compassion and caretaking is open to question, particular in problem-plagued communities that are being asked to care for traditionally stigmatized populations. That capacity for compassion and caretaking will have to be tested one community and one individual at a time.

Summary and Conclusions

The role of community in recovery has been viewed quite differently across the history of recovery mutual aid societies and within the professional world of addiction treatment. The modern emphasis on addiction and recovery as biopsychological processes is giving way to a greater appreciation of the role of social and cultural processes in the development and resolution of AOD problems. This shift rests on the recognition of the changing nature of communities, the role of community decay as a contributing source of AOD problems, the role of community support as an agent of healing, the need to nurture sustainable community-based recovery support systems, and the need to build recovery-oriented systems of care that extend recovery support services from the treatment institution to the natural environments of the clients being treated.

There is a growing sense that addiction treatment has become disconnected from its historical roots, detached from the larger and more enduring process of addiction recovery, and divorced from the grass roots communities out of which it was born. As the field evolved into a clinical specialty, it lost touch with its role as an active agent in enhancing the healing power of community. . In spite of significant new clinical technologies, addiction treatment suffers from a loss of such core functions as community education, social action, and community resource development, mobilization and linkage. Our focus should be not just on what professionalized services we can offer members of our local communities, but on how we can develop resources within these communities that diminish the need for professionalized structures of care and support.

Treatment organization that in their earliest years defined themselves as “community-based” are more likely today to define themselves as businesses. To recapture that founding identity, agencies must find ways to rejoin their communities and discover the natural healing powers that lie within these communities. By narrowly defining the sources of AOD problems within biomedical models, we have restricted our vision of the potential solutions to these problems. Perhaps it is time we rediscovered what was of value along that road the addictions field did not take in the transition from the 1960s to the 1970s. When universities became too isolated from the communities in which they were born, progressive educators called for these institutions to move back into the life of their communities--to become universities without walls. It is time we forged a system of addiction treatment and recovery without walls. Barriers to recovery and incentives for recovery exist in the community space surrounding those experiencing severe AOD problems. It is that space that marks the new (rediscovered) frontier for addiction treatment professionals.

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