**New Addiction Recovery Support Institutions:
Mobilizing Support beyond Professional Addiction Treatment
and Recovery Mutual Aid**

William L. White, MA, John F. Kelly, PhD, and Jeffrey D. Roth, MD

Abstract

For more than 150 years, support for the personal resolution of severe and persistent alcohol and other drug problems in the United States has been provided through three mechanisms: family, kinship, and informal social networks; peer-based recovery mutual aid societies; and professionally directed addiction treatment. This article: 1) briefly reviews the history of these traditional recovery supports, 2) describes the recent emergence of new recovery support institutions and a distinctive, all-inclusive culture of recovery, and 3) discusses the implications of these recent developments for the future of addiction treatment and recovery in the United States.

Keywords: Recovery mutual aid, recovery community organizations, recovery advocacy movement, recovery homes, recovery industries, recovery schools, recovery ministries, culture of recovery

Introduction

There is growing evidence that the central organizing construct guiding addiction treatment and the larger alcohol and other drug (AOD) problems arena is shifting from long-standing pathology and intervention paradigms toward a solution-focused recovery paradigm (El-Guebaly, 2012; Laudet, 2008; White, 2008a). Calls are increasing to extend the prevailing acute care model of addiction treatment to a model of sustained recovery management (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000) and to nest these expanded treatment and support models within larger recovery-oriented systems of care (Kelly & White, 2011; White, 2008b). Related trends include increased interests in defining recovery (Betty Ford Institute Consensus Panel, 2007); evaluating the effects of participation in recovery mutual aid societies on long-term personal recovery and social cost outcomes (Humphreys et al., 2004; Kelly & Yeterian, 2008); identifying effective linkage procedures between addiction treatment and recovery mutual aid societies (Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009; White & Kurtz, 2006); and expanding access to new forms of peer-based recovery support services (White, 2009b). There is also heightened interest in post-treatment recovery support mechanisms (McKay, 2009) for adults (Dennis & Scott, 2012) and for adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2007). This latter trend is encouraging,

particularly in light of the contention that recovery-focused "systems transformation" efforts that only focus on professional treatment and mutual aid miss opportunities to develop and mobilize broader addiction recovery support resources within the community (White, 2009b).

Cloud and Granfield (2008) introduced the term *recovery capital* to designate the collective internal and external resources that can be mobilized to initiate and sustain the resolution of AOD problems at a personal level. Traditionally, recovery capital exists as a continuum of assets within three distinct spheres: 1) support from family, kinship, and social networks; 2) generalized support from indigenous cultural institutions (e.g., the arenas of medicine, business, education, religion, and social welfare); and 3) the more specialized support provided by addiction recovery mutual aid groups and professionally directed addiction treatment. For more than 150 years, these latter specialized addiction recovery resources have provided the major help for persons with the most severe, complex, and prolonged AOD problems. There are, however, newly emerging addiction recovery support institutions that do not fit within the addiction recovery mutual aid or addiction treatment dichotomy.

This paper is an exercise in "connecting the dots" between what have been viewed as discreet developments to tell a larger story with potentially profound historical significance. The authors will: 1) briefly review the history of traditional recovery support structures in the United States, 2) describe the recent emergence of new recovery support institutions and an increasingly vibrant culture of recovery beyond the arenas of addiction treatment and recovery mutual aid, and 3) discuss how these developments could affect the future of addiction treatment and recovery.[1]

The History of Traditional Recovery Support Structures

Sophisticated epidemiological surveys and large scale clinical studies have triggered debates on whether AOD problems are self-regulating and self-limiting (as suggested by the former) or whether they require professional intervention and long-term care (as suggested by the latter). There is an extensive body of research on the phenomenon of "natural recovery"—the resolution of AOD problems without participation in addiction treatment or recovery mutual aid groups (Cunningham, 1999; Roizen, Cahalan, & Shanks, 1978; Sobell, Cunningham, & Sobell, 1996). This style of recovery is also reflected in a literary tradition of recovery memoirs within which people cast off AOD problems through a spectrum of religious, spiritual, and secular experiences outside the context of professional treatment or organized recovery support societies (For a review of early U.S. memoirs, see White, 2000). Even today, one does not have to travel far to find individuals who claim to have shed these problems without doing "rehab" or "meetings."

Recent community surveys revealing that most people (as many as 75%) who

---

[1] All historical events and trends not otherwise cited are abstracted from White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

resolve AOD-related problems do so without formal treatment or mutual aid involvement (Dawson, 1996; Lopez-Quintero et al., 2010; Schutte, Moos, & Brennan, 2006). This finding may be disconcerting to addiction professionals who spend their lives caring for those with the most severe, complex, and chronic AOD problems and who tend to see all AOD problems as progressive, chronically relapsing disorders resolved only through professional treatment and/or sustained involvement in a recovery mutual aid society. In contrast, those who study the trajectory of AOD problems in larger community populations have come to expect that such problems are self-limiting (rather than progressive) and resolvable through one's natural resources. The former perspective has been referred to as the "clinician's illusion" (Cohen & Cohen, 1984) and the latter as the "epidemiologist's illusion" (Moos & Finney, 2011).

Neither perspective, in isolation, fully encompasses the two overlapping worlds of AOD problems or adequately explains the marked differences between the course of AOD problems in clinical and community populations (Storbjork, & Room, 2008). The ability to resolve AOD problems across these populations seems to depend on the interaction between differing levels of personal/family/community recovery capital and different degrees of personal vulnerability and problem severity/complexity/chronicity (See White, 2008b for review).

The role external resources play in the resolution of AOD problems in clinical and community populations raises two interesting questions that set the stage for our continued discussions.

1. *Within the general population, could focused and sustained efforts to expand recovery support resources beyond addiction treatment and recovery mutual aid increase the prevalence of natural recovery from a broad spectrum of AOD problems?*
2. *Within clinical populations, could development of an expanded menu of community-based recovery support services be combined with addiction treatment and/or participation in recovery mutual aid to increase rates of successful recovery initiation and maintenance—particularly among those with the most severe substance use disorders?*

A Brief History of U.S. Addiction Recovery Treatment and Mutual Aid

The story of addiction recovery mutual aid in the United States begins with the rise of abstinence-based religious and cultural revitalization movements among Native American tribes (e.g., the Handsome Lake Movement [1799]; the Shawnee Prophet Movement [1805]). This tradition of culturally nuanced mutual support organized by and for people in addiction recovery continued in Native communities through subsequent religious and cultural revitalization movements, including the subsequent "Indianization of AA," the Red Road, and the contemporary Wellbriety Movement (Coyhis & White, 2006).

Organized mutual support for recovery in Euro-American communities began with people with alcohol problems seeking sanctuary within newly forming temperance societies (1830s) and extends through the more exclusive recovery-focused groups such as the Washingtonians (1840), recovery-focused temperance societies (1840s-1850s),

Dashaway Association (1859), the Ribbon Reform Clubs (1870s), and the Drunkard's Club (1871). These early efforts encompassed both secular and explicitly religious as well as abstinence-based and moderation-based frameworks of recovery (White, 1998, 2001a).

Following the collapse of the first wave of alcoholism recovery mutual aid groups, new transition groups, such as the Brotherhood of St. Luke (1904), the Jacoby Club (1910), and the United Order of Ex-Boozers (1914), set the stage for the founding of Alcoholics Anonymous (AA, 1935), the first efforts to adapt AA for narcotic addicts (Addicts Anonymous, 1947; Habit Forming Drugs, 1951; Hypes and Alcoholics, early 1950s), the founding of Narcotics Anonymous (NA) in New York City (1948), and the birth of NA as it is known today on the West Coast (1953, White, 2011).

In the years that followed, specialty groups branched from AA (e.g., the Calix Society [1947]; Al-Anon [1951]; Alateen [1957]), and AA's Twelve Steps were adapted for people dependent on other drugs—Potsmokers Anonymous (1968), Pills Anonymous (1975), Marijuana Anonymous (1989), Cocaine Anonymous (1982), Nicotine Anonymous (1985)—and for persons with co-occurring disorders (e.g., Dual Disorders Anonymous [1982], Dual Recovery Anonymous [1989], and Double Trouble in Recovery, [1993], White, 2011).

The latest phase in this history is the diversification of recovery mutual aid with the growth of secular and religious alternatives to Twelve-Step programs (e.g., Women for Sobriety [1975], American Atheists Alcohol Recovery Group [1980], Secular Organization for Sobriety/Save Our Selves [1985], Rational Recovery [1986], Smart Recovery® [1994], Moderation Management [1994], and LifeRing Secular Recovery [1999]). Explicitly religious recovery support groups also emerged (e.g., Alcoholics Victorious [1948], Alcoholics for Christ [1977], Overcomers Outreach [1977], Liontamers Anonymous [1980], Millati Islami [1989], and the Buddhist Recovery Network [2008], White, 1998, 2011).

Most recovery mutual aid organizations, perhaps because of the stigma attached to AOD problems, have operated as closed, self-contained organizations, but there are exceptions. There is a long history of social clubhouses spawned by mutual aid members. Clubhouses operate independently but in close tandem with their mutual aid organizations. Mutual aid organizations have also been involved in creating treatment organizations—from detoxification beds set up in the upstairs of Washingtonian Hall (in the 1840s) to AA co-founder Bill Wilson's vision of AA hospitals and AA missionaries. Recovery organizations have also been spawned inside addiction treatment organizations, including the Ollapod Club (1868), the Godwin Association (1872), and the Keeley Leagues (1891). The boundary between mutual aid and treatment has not always been a clear one.

Marking the early roots of today's specialty sector treatment system, an elaborate network of inebriate homes, medically directed inebriate asylums, private for-profit addiction cure institutes, and proprietary home cures for addiction flourished in the second half of the 19th century. These treatments, along with their mutual aid counterparts, collapsed in the opening decades of the 20th century in the wake of alcohol and drug prohibition movements. Following this collapse, cultural authority for the control of those with severe AOD problems passed to the criminal justice system (e.g., inebriate penal colonies, federal prisons), to the emergency rooms and "foul wards" of

large public hospitals, and to the back wards of aging state psychiatric asylums. Compassion and care gave way to sequestration, punishment, and control (White, 1998).

The resurgence of a vibrant, specialized addiction treatment field required decades of assertive advocacy and the development of replicable models of treatment between 1940 and 1965 (e.g., social setting detoxification, outpatient alcoholism clinics, residential models of alcoholism treatment, therapeutic communities, methadone maintenance, outpatient drug-free counseling clinics). Landmark legislation in the early 1970s set the stage for the rise of modern addiction treatment as a specialized health care field. The federal, state, and local partnership framed within this legislation and the subsequent extension of insurance coverage for the treatment of addiction led to the growth of specialized addiction treatment from a few hundred small programs to more than 15,000 institutions with a daily treatment capacity or more than 1.75 million patients served by a workforce of 130,000 full-time and 67,000 part-time and contractual workers (Kaplan, 2003; McLellan, Carise, & Kleber, 2003; SAMHSA, 2011).

This history has been presented elsewhere in far greater detail (White, 1998), but four themes within this history are pertinent to the current discussion. First, in spite of divergent philosophies and methods of care, the primary and almost exclusive unit of intervention within addiction treatment has been the *individual*—not the family, kinship network, or the larger natural environment in which recovery is sustained or extinguished.

Second, the primary model of addiction treatment delivery mimics the acute care (AC) hospital with its functions of screening, admission, assessment, brief (and ever-briefer) treatment, discharge, and termination of the service relationship. Early critics of this AC model of addiction treatment characterized it as a mechanistic, expensive illusion, disconnected from the processes of long-term recovery (Dodd, 1997). Later critiques focused on weaknesses of the AC model related to attraction, access, retention, inadequate service dose, low utilization of evidence-based clinical practices, weak linkage to communities of recovery, the absence of post-treatment monitoring and support, and high rates of re-addiction and re-admission (Kelly & White, 2011; White, 2008b).

Third, the methods of treatment were distinctly clinical in their orientation (e.g., professional roles and interventions adapted from the fields of psychiatry, psychology, and psychiatric social work), with a particular focus on biopsychosocial stabilization. Intervention models that focused on recovery community resource development and assertive linkage to community recovery support systems were briefly considered in the 1960s and early 1970s but rapidly gave way to more medicalized models of care and the subsequent professionalization and commercialization of addiction treatment (White, 2002). As a result, non-professional recovery resources in the local community came to be seen as an adjunct to treatment—an afterthought to the more important intrapersonal clinical work—as opposed to treatment being viewed as an adjunct to more accessible and enduring recovery maintenance resources in the community. Few modern programs defined their role as a catalyst for the development of non-clinical recovery support resources in the communities they served, in great part because such activities were not reimbursable within prevailing AC models of care.

There have been efforts to break out of these encapsulated categories of recovery mutual aid and clinically directed addiction treatment. The halfway house movement of

the 1950s sought a connecting bridge between these two worlds and to the larger process of community reintegration (Rubington, 1967); the Minnesota Model programs sought to blend these worlds within a treatment milieu (Spicer, 1993); the social model of recovery pioneered in California provided a distinct alternative to clinical treatment (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Shaw & Borkman, 1990/1991); and early therapeutic communities existed as cultures of their own isolated from both mainstream addiction treatment and mainstream recovery mutual aid groups (Janzen, 2001). In spite of such exceptions, professionally directed addiction treatment and recovery mutual aid groups have remained, until recently, the primary specialized recovery support institutions.

New Addiction Recovery Support Institutions

The self-containment of recovery mutual aid organizations and the similar self-containment and isolation of the addiction treatment enterprise has created a void of unmet need in the larger community for a broader spectrum of recovery support resources. That need is being filled in part by the rise of new recovery support institutions and a broader culture of recovery.

New Addiction Recovery Advocacy Movement: In the late 1990s, new grassroots recovery community organizations (RCOs) began dotting the American landscape, stimulated in part by the Center for Substance Abuse Treatment's Recovery Community Support Program that in 1998 began providing seed money for such organizations (Kaplan, Nugent, Baker & Clark, 2010). RCOs are organized by and on behalf of people in recovery and participate in a wide variety of recovery advocacy and peer recovery support activities. In 2004, the White House-initiated Access to Recovery program also began providing grants to states and tribal organizations for peer and other recovery support services.

In 2001, RCO representatives from around the country met in St. Paul, Minnesota, to launch what has since been christened the new addiction recovery advocacy movement. The 2001 meeting brought together local RCOs and existing national advocacy organizations such as the National Council on Alcoholism and Drug Dependence (NCADD), the Johnson Institute's Alliance Project, and the Legal Action Center. A new organization, Faces and Voices of Recovery, was created at the summit that has since provided the connecting tissue for RCOs across the U.S. and beyond. In 2011, these RCOs formed the Association of Recovery Community Organizations (White, 2006).

The goals of what is rapidly becoming an international recovery advocacy movement (Roth, 2010) include: 1) the political and cultural mobilization of communities of recovery, 2) recovery-focused public and professional education, 3) advocacy of pro-recovery laws and social policies, 4) advocacy for a recovery-focused redesign of addiction treatment, 5) promotion of peer-based recovery support services, 6) support for international, national, state, and local recovery celebration events, and 7) promotion of a recovery research agenda (White, 2007). The movement's core organizing themes are displayed in Table 1.

Table 1: Kinetic Ideas of the New Addiction Recovery Advocacy Movement
1. Addiction recovery is a reality in the lives of millions of individuals, families, and communities.
2. There are many paths to recovery—and all are cause for celebration.
3. Recovery flourishes in supportive communities.
4. Recovery is a voluntary process.
5. Recovering and recovered people are part of the solution; recovery gives back what addiction has taken—from individuals, families, and communities (White, 2006).

As a point of perspective, in 1976, 52 prominent Americans publicly announced their long-term recovery from alcoholism as part of the National Council of Alcoholism's Operation Understanding—an anti-stigma campaign aimed at challenging stereotypes about alcoholism. It was the largest public "coming out" of people in recovery in the twentieth century. In September 2011, more than 100,000 people in recovery and their families, friends, and allies participated in more than 200 public Recovery Month celebration events across the United States. That magnitude of cultural and political mobilization of people in recovery is historically unprecedented. The present recovery advocacy movement is distinctive in its explicit focus on eliminating policy barriers to addiction recovery and promoting a policy environment in which addiction recovery can flourish.

Recovery Community Centers (RCCs): Many RCOs are creating local recovery community centers, and some states (e.g., Connecticut, Vermont, Rhode Island) have created regional networks of RCCs. RCCs host recovery support meetings; provide recovery coaching; provide linkage to a wide spectrum of resources including recovery housing and recovery-conducive education and employment; serve as a site for recovery-focused social networking; and serve as a central hub for advocacy, peer support, and community service activities. In a recent year, for example, Vermont's nine recovery community centers, with just 15 part-time staff and 150 volunteers (30,000 hours of volunteer support per year), were open 70 hours per week, hosted 127 recovery support meetings per week, and had a total of 143,903 visits—25% of whom had less than a year of recovery, and 33% of whom had never participated in addiction treatment (White, 2009b).

Recovery Homes: Recovery residences are distinguished from addiction treatment by their homelike environment, self-determined lengths of stay, democratic self-governance, and their reliance on experiential rather than professional authority—no paid professional staff. The majority of recovery homes are financially self-supported by the residents. Most visible among the recovery residence network is Oxford House. Founded in 1975, Oxford House has grown to include more than 1,500 recovery homes in 48 states (432 cities) with a collective annual occupancy of more than 24,000 recovering people (Molloy & White, 2009; Oxford House Inc. Annual Report, 2011).

Jason and colleagues have conducted extensive studies of Oxford House and have found that the prospects of long-term recovery rise with length of stay (Jason, Davis, & Ferrari, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006; Jason et al., 2007). These outcomes extend to women, racial and ethnic minorities, and people with co-occurring

psychiatric disorders (d'Arlach, Olson, Jason, & Ferrari, 2006; Ferrari, Curtin-Davis, Dvorchak, & Jason, 1997; Majer et al., 2008).

Indicative of the spread of recovery homes, a recent survey in Philadelphia identified 21 city-funded recovery residences (primarily for persons re-entering the community from the criminal justice system) and a larger network of 250 financially self-supported recovery homes (Johnson, Martin, Sheahan, Way, & White, 2009). In 2011, representatives from the growing national network of recovery homes founded the National Association of Recovery Residences toward the aims of assuring the quality of recovery residences and linking them into a more integrated network of long-term recovery support.

Recovery Schools: People in recovery face great obstacles in entering or returning to secondary and post-secondary schools—settings that have been characterized as "abstinence-hostile environments" (Cleveland, Harris, Baker, Herbert, & Dean, 2007). A broad spectrum of programs, collectively embraced within the rubric of the "recovery school movement," has emerged to provide recovery support within the academic environment (Roth & Finch, 2010). Beginning with Brown University, Rutgers University, Texas Tech University, and Augsburg College, specialized campus-based recovery support programs have provided an array of recovery supports ranging from scholarships for students in recovery, sober housing, on-campus recovery support groups, recovery coaching, academic mentoring, study groups, sober social activities, and community service projects. Since Ecole Nouvelle (now Sobriety High) in Minnesota was opened in 1986, there has been a similar growth in the development of recovery high schools. Twenty-five recovery high schools opened across the United States between 1999 and 2005 (White & Finch, 2006).

Studies to date of school-based recovery support programs confirm high rates of uninterrupted abstinence (70-80%), early intervention and retention of students following any AOD use, excellent academic performance, high class attendance rates (90-95%), high graduation rates, and high rates (65%) of college attendance among students in recovery high schools (Botzet, Winters, & Fahnhorst, 2007; Cleveland et al., 2007; Gibson, 1991; Harris, Baker, Kimball, & Shumway, 2007; Moberg & Finch, 2007; White, 2001b). The growth of school-based programs led to the formation in 2002 of the Association of Recovery Schools.

Recovery Industries: Although obtaining meaningful, recovery-conducive work is a significant challenge for many people entering recovery within the current economic climate, vocational counseling/training, assertive linkage to recovery-supportive employment, and job coaching are not standard components of modern specialty-sector addiction treatment in the United States (Magura, 2003; Room, 1998). Several recent community responses to employment needs of people in recovery are worthy of note. First, RCOs, often through their recovery community centers or recovery coaching projects, are establishing employment clearinghouses and incorporating work-related support into the recovery coaching process. Second, two specialized types of employment resources are emerging specifically for people in recovery entering or re-entering the workforce. The first consists of recovery-friendly employers who have had good experiences hiring people in recovery and who remain receptive to such hiring, particularly those in a structured recovery support process. Examples of such employers range from small businesses like Zingerman's Deli in Ann Arbor, Michigan, to large

businesses such as Venturetech—a manufacturer of hydraulic pumps in Houston, Texas (See http://www.recoveryatwork.org/). The second type of specialized employment resource involves businesses established by people in recovery who exclusively employ people in recovery, e.g., Recovery at Work in Atlanta, Georgia; Business Enterprises in Portland, Oregon. In these settings, people in recovery have the opportunity to acquire work skills, establish a recent employment history, and work with and be supervised by other people in recovery as a pathway to continued employment at these sites or to develop a work history that increases opportunities for alternative employment opportunities (White, 2009b).

Recovery Ministries: Churches, mosques, synagogues, and temples have become increasingly involved in providing addiction recovery support services through the sponsorship of their respective faith communities. These efforts include recovery-friendly churches (e.g., Mercy Street in Houston, Texas), mega-churches with one or more "recovery pastors" (e.g., Saddleback Church in Southern California), lay leaders of church-sponsored recovery support groups (e.g., the spread of Celebrate Recovery in more than 10,000 churches), recovery-focused worship services and workshops, recovery churches (e.g., Central Park Recovery Church in St. Paul, MN), and faith-based recovery colonies (e.g., Dunklin Memorial Camp in Okeechobee, Florida, Swanson & McBean, 2011). One of the most well-known and enduring recovery ministries is that led by Reverend Cecil Williams at Glide Memorial Methodist Church in the Tenderloin District of San Francisco, California (Williams, 1992). Many of the Christian recovery ministries are linked and mutually supported through the National Association for Christian Recovery founded in 1989. The growth of recovery ministries has also spawned a support industry whose mission is to spread recovery ministries nationally and internationally, e.g., NET Institute (White, 2009b).

Recovery community organizations, recovery community centers, recovery residences, recovery schools, recovery industries, and recovery ministries share several distinctive features. First, these new recovery support institutions fit neither the designation of addiction treatment nor designation as a recovery mutual aid fellowship. Second, they provide recovery support needs not directly addressed through addiction treatment or recovery mutual aid societies. Third, their target of support extends beyond the individual. Where addiction treatment and mutual aid provide personal guidance during the recovery process, these new recovery support institutions seek to create a physical and social world, including a policy environment, in which personal and family recovery can flourish. Fourth, these new institutions reflect, and are in turn being shaped by, a larger culture of recovery that transcends association with any treatment or recovery mutual aid organization.

The Coming of Age of an American Culture of Recovery

The transition from addiction to recovery is a personal journey, but it can also involve a journey between two physical and social worlds—from a culture of addiction to a culture of recovery (White, 1996). Historically, this transition has been marked by shedding the trappings and folkways of the culture of addiction (language, values, symbols, rituals, relationships, dress, etc.) and replacing these with the cultural folkways of a particular treatment institution or recovery mutual aid society. What is significant

today is the rise of a culture of recovery in the United States through a process of mutual identification that transcends where one's recovery started and the meetings one may or may not attend.

A broader cultural and political mobilization of people in recovery across diverse pathways and styles of recovery is emerging—a broader consciousness as *people in recovery*. People within particular recovery clans have been meeting in large numbers since the mass Washingtonian meetings of the 1840s, but people walking arm-in-arm on public streets in the U.S. representing an array of secular, spiritual, and recovery pathways and walking not as AA, NA, WFS, SOS, LifeRing, or Celebrate Recovery members but as "people in recovery" is historically unprecedented. With that breakthrough has come the rapid rise and maturation of what might be thought of as a "non-denominational" culture of recovery.

With this broadened sense of identity, previously marginalized individuals are undergoing processes of consciousness-raising, mobilization, and culture-making. This culture is providing a diverse menu of words, ideas, metaphors, rituals, support institutions, support roles, and recovery support services to ease the process of recovery initiation, recovery maintenance, and enhanced quality of life in long-term recovery. What recovering people historically experienced inside treatment or a recovery fellowship—connection, mutual identification, and community—is now being extended beyond the walls of these institutions and meeting rooms.

The extent to which a culture of recovery in the United States is emerging beyond the arenas of addiction treatment and recovery mutual aid is illustrated in Table 2.

Table 2: The Culture of Recovery in the United States: Emerging Elements and Representative Activities

Recovery Cultural Element	Representative Activities
Values	RCO identification of "recovery values" (e.g., primacy of personal recovery, singleness of purpose/mission fidelity, organizational transparency, honesty, humility, simplicity, respect, tolerance, inclusion, stewardship); Recovery Bill of Rights—Faces and Voices of Recovery.
History	History clubs, e.g., AA History Lovers; groups working on state/local recovery group histories; growing archivist movement within mutual aid groups; a book on the history of addiction recovery has gone through 10+ printings since 1998.
Language	Recovery-focused language audits; multiple advocacy papers on language challenging prevailing words and ideas (e.g., challenging the pervasive use of "abuse" within the AOD problems arena that have received recent research support, Kelly, Dow, & Westerhoff, 2011; Kelly & Westerhoff, 2010; White, 2006); Faces & Voices of Recovery Messaging Training.
Iconic Symbols	Recovery-themed posters, greeting cards, jewelry; the color amethyst (purple) used in t-shirts, posters, buttons, etc. from the Greek *amethystos*, meaning "not intoxicated"; and the butterfly, which symbolizes transition and rebirth.

Television	Recovery Television Network; increased recovery-themed cable television programming; heightened recovery-themed programming by the national networks; broader corporate sponsorship of recovery programming and activities.
Film	Recovery-themed documentaries and independent films, e.g., *The Secret World of Recovery*, *The Healing Power of Recovery*, *The Wellbriety Movement: Journey of Forgiveness*, *Lost in Woonsocket*, *Bill W*; growth in recovery film festivals.
Radio	Increased presence of recovery on conventional and Internet radio; Recovery Radio Network; Recovery 101 Radio; Recovery Coast-to-Coast; Boston Recovery Radio; Afflicted and Affected; Recovery Matters; Steppin' Out Radio.
Theatre	Improbable Players in Watertown Square, MA; San Francisco Recovery Theatre; Phoenix Theatre Group (Helping Recovering Addicts via Art); The Vision Troupe (Bob LoBue's play *Visions*).
Music	Major recording artists expressing their recovery through music (e.g., Eminem, Mary J. Blige); Recovery Idol in Philadelphia, PA; the growing network of recovery music festivals—Sober in the Sun, Half Moon Sober Fest; Rockstar Superstar Project (Rebranding Sobriety).
Art	Recovery Murals in Philadelphia; growth of Recovery Fine Arts Festivals.
Literature	Recovery memoirs replacing drink/drug memoirs (Oksanen, 2012); papers and pamphlets related to recovery advocacy; annual recovery essay contests; recovery support for writers, e.g., Writers in Treatment.
Media Communications	Recovery lifestyle magazines—*Journey: A Magazine of Recovery*; *Recovery Living*, *Renew Magazine, Serene Scene Magazine*—and books; *Addictions and Answers: Dr. Dave and Bill*; *New York Daily News* column; growth in recovery blogs and sober lifestyle websites, e.g., http://www.thefix.com/content/blogs.
Comedy	Recovery comedians, e.g., Mark Lundholm, Tara Handron, Jessie Joyce; Laughs without Liquor—Recovery Comedy Tour.
Sports	Philadelphia's Clean Machine and Milwaukee's Rebound Basketball teams; Colorado-based Phoenix Multisport.
Social Clubs	Recovery clubhouses, Recovery Coffee Shop, Wichita, Kansas, and other coffee shops/cafes owned and operated by recovering people as recovery gathering sites; recovery dances; social events at recovery community centers.
Internet-based Social Networking	Recovery-focused social networking on My Space, Facebook, and Twitter; www.intherooms.com; www.addictiontribe.com; www.beatingaddiction.com; www.soberrecovery.com; www.sobercircle.com; http://myrecoveryspace.com/; http://www.cyberrecovery.net/forums/.
Travel	Recovery-focused travel, e.g., www.TravelSober.com; www.SoberCelebrations.com; www.SoberCruises.com;

	www.SoberTravelers.com.
Recovery Community Leadership Development	Faces & Voices of Recovery Leadership Academy; Recovery Corps, Baltimore, MD; training programs to prepare people to serve as recovery coaches, e.g., Connecticut Community of Addiction Recovery; McShin Foundation; recovering people participating in mapping community recovery resources (e.g., Philadelphia).
Community Service	Community Volunteer Corps, Portland, Oregon; Missouri Recovery Network's community cleanup projects.
Science	Participation in recovery-focused scientific research (e.g., National Quit and Recovery Registry); people in recovery participating in development of recovery measures with research scientist Lee Ann Kaskutas, PhD; people in recovery pursuing advanced education toward goal of conducting recovery research.
Recovery Advocacy Websites	www.facesandvoicesofrecovery.org (see for listing of RCOs across the country); www.recoveryiseverywhere.com; www.recoverymonth.gov.
National Recovery Celebration Events	Annual Rally for Recovery; Recovery Month events; America Honors Recovery Awards.
International Exchanges	U.K. recovery advocates visiting U.S. RCOs via Winston Churchill Scholarships; U.S. recovery advocates speaking at public recovery rallies in Europe, Asia, Africa, and South America.

This brief description does not adequately capture the growing sense of community experienced by people across pathways of recovery and the potential import of this trend to the future of recovery. The community-building process that is currently underway is comparable to that experienced at the height of the civil rights movement, the women's rights movement, and the LGBT rights movement. What remains to be seen are the limits of mutual identification and the boundaries of inclusion/exclusion within this emerging culture of recovery.

Implications of the New Support Institutions for Treatment, Mutual Aid, and the Enhancement of Recovery

For more than 150 years, addiction recovery support beyond the natural resources of family, extended family, and social networks and general support from mainstream social institutions, has been provided by two specialized cultural institutions: addiction recovery mutual aid societies and professionally directed addiction treatment. In this paper, we have documented the emergence of new recovery support institutions (recovery community organizations, recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries) and a broader culture of recovery in the United States.

With the exception of the growing body of research on recovery residences, particularly the Oxford House network, and preliminary studies on collegiate recovery programs, little scientific attention has been directed toward investigating these new support mechanisms for addiction recovery. These new recovery supports also exist

beyond the consciousness of the fields' clinical and policy leaders. The questions we pose below underscore our belief that the changes outlined in this paper constitute a significant milestone in the history of addiction recovery—a milestone that will have profound implications to the future study and treatment of alcohol and other drug problems.

Historical Identity and Cultural Status: How will new recovery support institutions affect the identities and cultural status of addiction recovery mutual aid groups and addiction treatment institutions and their respective claims of cultural ownership of AOD problems?

Utilization and Effectiveness of Existing Institutions: Will the spread of these new recovery support structures serve to increase rates of entrance, early retention, and continued participation in addiction treatment and formal recovery mutual aid groups? Will recovery rates within local addiction treatment and recovery mutual aid groups rise in tandem with the development of these broader recovery support institutions? Could addiction treatment organizations increase the long-term recovery outcomes of those they serve by taking a more assertive role in the development, support, and mobilization of indigenous community recovery support resources?

Natural Recovery: Will the prevalence of natural recovery—the resolution of AOD problems without participation in recovery mutual aid groups or professional treatment—increase under the influence and heightened accessibility of these new recovery support structures? Will new recovery support structures serve primarily as adjuncts or alternatives to addiction treatment and recovery mutual aid groups?

Active Ingredients: What are the similarities and differences in the active ingredients (elements that elevate long-term recovery outcomes) within new recovery support institutions compared to those within addiction treatment and recovery mutual aid groups?

Potent Combinations/Sequences: Are there particularly potent combinations or sequences of addiction treatment, recovery mutual aid, and participation in broader recovery support institutions that generate significantly higher rates of long-term recovery than could have been achieved through the use of each in isolation, e.g., combining outpatient treatment, mutual aid, and sober housing (Polcin, Korcha, Bond, & Galloway, 2010)?

Responses across Diverse Populations: Are there particular populations for whom participation in these broader recovery support institutions are indicated or contraindicated? Will new recovery support institutions reach ethnic group members with severe substance use disorders who currently underutilize addiction treatment and mainstream recovery mutual aid resources (Chartier & Caetano, 2011)?

The cultural management of AOD problems has historically focused on two targets: the individual and the community environment, with the activities of traditional recovery support institutions (i.e., professionally directed treatment and mutual aid organizations) focused almost exclusively on the individual. The trends outlined in this paper mark a movement into the chasm between the individual and the community. It is our expectation that greater attention will be given to improving recovery outcomes through strategies aimed at increasing *community recovery capital* (White & Cloud, 2008). This will involve a blending of traditional clinical strategies of intervention with strategies of cultural revitalization and community development. With that will come

studies of the role of community recovery capital (including the emerging resources described in this paper), as distinguished from the role of personal vulnerabilities and assets, in predicting long-term recovery outcomes.

Already rising from these new recovery support institutions is the concept of *community recovery*—the idea that broader social systems beyond the individual have been significantly wounded by severe and prolonged AOD dependence and related problems that may require a process of consciousness-raising and sustained healing. Coyhis (Coyhis & White, 2002) has referred to this community recovery process as a "healing forest" within which the individual, family, community, and culture are healed simultaneously.

It is incumbent on addiction professionals to become students of and participants within this national and international transformation of the ecology of recovery (2009a). The goal of the new recovery advocacy movement is to create a world in which recovery can flourish. It appears the construction of that world is well under way.

References

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. doi:10.1016/j.jsat.2007.06.001

Borkman, T. J., Kaskutas, L. A., Room, J., Bryan, K., & Barrows, D. (1998). An historical review and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, *15*(1), 7-17. doi:10.1016/S0740-5472(97)00244-4

Botzet, A. M., Winters, K., & Fahnhorst, T. (2007). An exploratory assessment of a college substance abuse recovery program: Augsburg College's StepUP Program. *Journal of Groups in Addiction and Recovery, 2*(2-4), 257-270. doi:10.1080/15560350802081173

Chartier, K. G., & Caetano, R. (2011). Trends in alcohol services utilization from 1991-1992 to 2001-2002: Ethnic group differences in the U.S. population. *Alcoholism: Clinical & Experimental Research*, *35*(8), 1485-1497. doi:10.1111/j.1530-0277.2011.01485.x

Cleveland, H. H., Harris, K. S., Baker, A. K., Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment, 33*(1), 13-23. doi:10.1016/j.jsat.2006.11.005

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical concept. *Substance Use and Misuse, 43*(12-13), 1971-1986. doi:10.1080/10826080802289762

Cohen, P., & Cohen, J. (1984). The clinician's illusion. *Archives of General Psychiatry, 41*, 1178-1182.

Coyhis, D., & White, W. (2002). Addiction and recovery in Native America: Lost

history, enduring lessons. *Counselor, 3*(5), 16-20.

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

Cunningham, J. (1999). Untreated remission from drug use: The predominant pathway. *Addictive Behaviors*, *24*(2), 267-270. doi:10.1016/S0306-4603(98)00045-8

d'Arlach, L., Olson, B. D., Jason, L. A., & Ferrari, J. R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, *31*(1-2), 121-131. doi:10.1300/J005v31n01_11

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. doi:10.1111/j.1530-0277.1996.tb01685.x

Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

Dennis, M. L., & Scott, C.K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence, 121*, 10-17. doi:10.1016/j.drugalcdep.2011.07.026

Dodd, M. H. (1997). Social model of recovery: Origin, early features, changes and future. *Journal of Psychoactive Drugs*, *29*(2), 133-139.

El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine, 6*, 1-9. doi:10.1097/ADM.0b013e31823ae540

Ferrari, J. R., Curtin-Davis, M., Dvorchak, P., & Jason, L. A. (1997). Recovering from alcoholism in communal-living settings: Exploring the characteristics of African American men and women. *Journal of Substance Abuse*, *9*, 77-87. doi:10.1016/S0899-3289(97)90007-9

Gibson, R. L. (1991, April). *School-based recovery support: The time is now*. Presented at the annual convention of the American Association of Counseling and Development, Reno, Nevada, April 21-24.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). The effect of Assertive Continuing Care on continuing care linkage, adherence, and abstinence following residential treatment for adolescents with substance use disorders. *Addiction*, *102*, 81-93. doi:10.1111/j.1360-0443.2006.01648.x

Harris, K. S., Baker, A. K., Kimball, T. G., & Shumway, S. T. (2007). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 220-237. doi:10.1080/15560350802080951

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158. doi:10.1016/S0740-5472(03)00212-5

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

Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*, *32*, 803-818. doi:10.1016/j.addbeh.2006.06.014

Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health, 96*, 1727-1729. doi:10.2105/AJPH.2005.070839

Jason, L. A., Olson, B. D., Ferrari, J. R., Majer, J. M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, *102*, 1114-1121. doi:10.1111/j.1360-0443.2007.01846.x

Johnson, R., Martin, N., Sheahan, T., Way, F., & White, W. (2009). *Recovery resource mapping: Results of a Philadelphia Recovery Home Survey*. Philadelphia, PA: Philadelphia Department of Behavioral Health and Mental Retardation Services. Posted at www.facesandvoicesofrecovery.org

Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment.

Kaplan, L., Nugent, C., Baker, M., & Clark, H. W. (2010). Introduction: The Recovery Community Services Program. *Alcoholism Treatment Quarterly*, *28*, 244-255. doi:10.1080/07347324.2010.488522

Kaskutas L. A., Subbaraman, M. S., Witbrodt, J., & Zemore, S. E. (2009). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ): A group format 12-step facilitation approach. *Journal of Substance Abuse Treatment, 37*(3), 228-239. doi:10.1016/j.jsat.2009.01.004

Kelly, J. F., Dow, S. J., & Westerhoff, C. (2011). Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms. *Journal of Drug Issues*, *40*, 805-818. doi:10.1177/002204261004000403

Kelly, J. F., & Westerhoff, C. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*, *21*, 202-207. doi:10.1016/j.drugpo.2009.10.010

Kelly, J. F., & White, W. L. (2011). *Addiction recovery management: Theory, research and practice*. New York: Springer.

Kelly J. F., & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue, & J. R. Cunningham (eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

Laudet, A. B. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and resrach. *Substance Use & Misuse*, *43*, 2001-2020. doi:10.1080/10826080802293459

Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106*(3), 657-669. doi:10.1111/j.1360-0443.2010.03194.x

Magura, S. (2003). The role of work in substance dependency treatment: A preliminary overview. *Substance Use and Misuse*, *38*(11-13), 1865-1876.

Majer, J. M., Jason, L. A., North, C. S., Ferrari, J. R., Porter, N. S., Olson, B.,…Molloy, P. (2008). A longitudinal analysis of psychiatric severity upon outcomes among substance abusers residing in self-help settings. *American Journal of Community Psychology, 42*(1-2), 145-153. doi:10.1007/s10464-008-9190-z

McKay, J. R. (2009). *Treating substance use disorders with adaptive continuing care*. Washington, D.C.: American Psychological Association.

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment*, *25*, 117-121. doi:10.1016/S0740-5472(03)00156-9

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

Moberg, D. P., & Finch, A. J. (2007). Recovery high schools: A descriptive study of school programs and students. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 128-161. doi:10.1080/15560350802081314

Molloy, P., & White, W. L. (2009). Oxford Houses: Support for recovery without relapse. *Counselor, 11*(2), 28-33.

Moos. R. H., & Finney, J. W. (2011). Commentary on Lopez-Quintero et al. (2011): Remission and relapse—the Yin-Yang of addictive disorders. *Addiction*, *106*, 670-671. doi:10.1111/j.1360-0443.2010.00003284.x

Oksanen, A. (2012). To Hell and back: Excessive drug use, addiction, and the process of recovery in mainstream rock autobiographies. *Substance Use & Misuse*, *47*, 143-154. doi:10.3109/10826084.2012.637441

Oxford House, Inc. annual report (2011). Sliver Springs, MD: Oxford House, Inc.

Polcin, D. L., Korcha, R., Bond, J., & Galloway, G. (2010). Eighteen month outcomes for clients receiving combined outpatient treatment and sober living houses. *Journal of Substance Use*, *15*(5), 352-366. doi:10.3109/14659890903531279

Roizen, R., Cahalan, D., & Shanks, P. (1978). "Spontaneous remission" among untreated problem drinkers. In D. B. Kandel (Ed.), *Longitudinal research on drug use, empirical findings and the methodological issues* (pp. 197-221). New York: John Wiley & Sons.

Room, J. (1998). Work and identity in substance abuse recovery. *Journal of Substance Abuse Treatment*, *15*(1), 65-74. doi:10.1016/S0740-5472(97)00250-X

Roth, J., & Finch, A. (2010). *Approaches to substance abuse and addiction in education communities: a guide to practices that support recovery in adolescents and young*. Philadelphia: Taylor & Francis Group.

Roth, J. D. (2010). Crossing international boundaries in recovery from addiction. *Journal of Groups in Addiction & Recovery, 5*(3-4), 179-182. doi:10.1080/1556035X.2010.523335

Rubington, E. (1967). The halfway house for the alcoholic. *Mental Hygiene, 51*, 552-560.

Schutte, K. K., Moos, R. H., & Brennan, P. L. (2006). Predictors of untreated remission from late-life drinking problems. *Journal of Studies on Alcohol*, *67*, 354-362.

Shaw, S., & Borkman, T. (1990/1991). *Social model alcohol recovery: An environmental approach*. Burbank, CA: Bridge Focus, Inc.

Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol
    problems with and without treatment: Prevalence in two population surveys.
    American Journal of Public Health, *86*(7), 966-972.

Spicer, J. (1993). *The Minnesota Model: The evolution of the interdisciplinary approach
    to addiction recovery*. Center City, Minnesota: Hazelden Educational Materials.

Storbjork, J., & Room, R. (2008). The two worlds of alcohol problems: Who is in
    treatment and who is not? *Addiction Research and Theory*, *16*(1), 67-84.
    doi:10.1080/16066350701578136

Substance Abuse and Mental Health Services Administration (SAMHSA). (2011).
    *National Survey of Substance Abuse Treatment Services (N-SSATS): 2010. Data
    on substance abuse treatment facilities* (DASIS Series S-59, HHS Publication No.
    (SMA) 11-4665). Rockville, MD: Substance Abuse and Mental Health Services
    Administration.

Swanson, L., & McBean, T. (2011). *Bridges to grace: Innovative approaches to
    recovery ministry*. Grand Rapids, MI: Zendervan.

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

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

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

White, W. L. (2000). Listening to Lazarus: The voices of America's first "Reformed
    Drunkards". *Contemporary Drug Problems, 26*, 533-542.

White, W. L. (2001a). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment
    Quarterly, 19*(1), 1-21. doi:10.1300/J020v19n02_01

White, W. L. (2001b). Recovery university: The campus as a recovering community.
    Student Assistance Journal, 13(2), 24-26.

White, W. L. (2002). A lost vision: Addiction counseling as community organization.
    Alcoholism Treatment Quarterly, *19*(4), 1-32. doi:10.1300/J020v19n04_01

White, W. L. (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.

White, W. L. (2007). The new recovery advocacy movement in America. *Addiction,
    102,* 696-703. doi:10.1111/j.1360-0443.2007.01808.x

White, W. L. (2008a). Recovery: Old wine, flavor of the month or new organizing
    paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.
    doi:10.1080/10826080802297518

White, W. L. (2008b). *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. L. (2009a). The mobilization of community resources to support long-term
    addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158.
    doi:10.1016/j.jsat.2008.10.006

White, W. L. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L. (2011). *A chronology of recovery mutual aid groups in the United States*. Retrieved March 3, 2012 from www.williamwhitepapers.com.

White, W. L., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

White, W. L., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58.

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