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## **Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation**

### **Executive Summary**

**William L. White, MA**

The history of addiction treatment and recovery in the United States contains a rich “wounded healer” tradition. For more than 275 years, individuals and families recovering from severe alcohol and other drug problems have provided peer-based recovery support (P-BRS). Formal peer-based recovery support services (P-BRSS) are now being delivered through diverse organizations and roles and are emerging as a critical component of “recovery management” and “recovery-oriented systems of care.” For the past year, I have researched the history and status of peer recovery support in the United States. The results of this review are now available in a new 250+ page monograph published by the Center for Substance Abuse Treatment’s Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services. A PDF of the monograph is available for downloading and hard copies for purchase are both available at [www.glatc.org](http://www.glatc.org).

This issue of *Counselor* provides an executive summary of the new monograph. I hope it will stimulate much discussion about the history of the role of addiction counselors and the emergence of new models of peer-based recovery support.

### **Introduction**

- The organizing principle for providing care for people with alcohol and other drug problems is shifting from pathology and intervention paradigms to a long-term recovery paradigm.
- Evidence of this shift can be seen in the shift in emphasis within addiction treatment from models of biopsychosocial stabilization to models of sustained recovery management.

- Recovery management models include assertive interventions to shorten addiction careers, lengthen recovery careers, and enhance the quality of individual/family life in long-term recovery.
- Peer-based recovery support (P-BRS) and formal peer-based recovery support services (P-BRSS) constitute central recovery management strategies and a core component of recovery-oriented systems of behavioral health care.
- This monograph reviews the history, operational principles, service practices, and scientific status of P-BRS and P-BRSS as well as their future relationship with professionally-directed addiction treatment.

## **Chapter One: Defining Peer-Based Recovery Support Services**

- Peer-based recovery support (P-BRS) is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from alcohol and/or other drug-related problems.
- Peer-based recovery support is provided by people who are experientially credentialed.
- There are substantial differences between models of peer recovery support and models of professionally-directed addiction treatment.
- P-BRS can be delivered through a variety of organizational venues and a variety of service roles (including paid and volunteer recovery support specialists).
- The governance structures of P-BRS vary in the span and degree of peer control (peer-owned, peer-directed, or peer-delivered).
- Peer-based recovery support services (P-BRSS) are a form of P-BRS delivered through more formal organizations and through more specialized roles.
- Asset allocation schemes for P-BRSS include entrepreneur models (excess assets returned to private owner/investors), institutional models (excess assets reinvested in development of the organization), and stewardship models (excess assets reinvested in recovery community development).
- The core functions of P-BRSS span the stages of recovery initiation/stabilization, recovery maintenance, and enhancement of quality of life in long-term recovery and may encompass support at individual, family, neighborhood, and community levels.
- P-BRSS are distinguished by their recovery focus; mobilization of personal, family, and community recovery capital to support long-

term recovery; respect for diverse pathways and styles of recovery; focus on immediate recovery-linked needs; use of self as a helping instrument; and emphasis on continuity of recovery support over an extended period of time.

- P-BRSS may serve as an adjunct or alternative to professionally-directed addiction treatment.

## **Chapter Two: History of Peer-Based Recovery Support Services**

- Addiction recovery mutual-aid societies and the specialty sector of addiction treatment emerged in response to the social stigma attached to AOD problems and the history of service exclusion, service extrusion, and ineffective and harmful interventions that individuals and families experienced in their encounters with mainstream health and human service institutions.
- Addiction recovery mutual-aid societies have experienced substantial growth (membership size and geographical dispersion of local meetings), pathway diversification (secular, spiritual, and religious recovery societies), specialization (meetings focused on age, gender, drug choice, and special needs), and new support media (growth of telephone- and internet-based support).
- A growing number of religious and cultural revitalization movements are embracing abstinence and creating unique cultural and religious pathways of recovery initiation and maintenance.
- People in recovery have sought service roles as a natural extension of the service ethic within communities of recovery and as a backlash against ineffective and disrespectful professional interventions.
- The services recovering people have provided to individuals and families suffering from AOD problems have emphasized service relationships that are natural, equal, reciprocal, voluntary, sustained (potentially life-long), non-bureaucratic, and non-commercialized.
- P-BRSS constitute an effort to recapture dimensions of support lost in the professionalization of addiction counseling and the weakening of the service ethic within communities of recovery that accompanied the rise of an “alcohol and drug abuse industrial complex” (Hughes, 1974).
- People in recovery have been cyclically included and excluded from leadership and service roles within addiction treatment and the broader arena of recovery support services.

- Recovering people are awakening both politically and culturally and are generating new recovery support institutions that compliment, and in some circumstances, compete with, professionally-directed addiction treatment.
- New recovery support institutions include grassroots recovery community organizations, recovery homes and colonies, recovery industries, recovery schools, recovery ministries and recovery churches, recovery-focused media (radio, television, cinema), and recovery arts (music, literature, film, comedy).
- Recovering people are again moving into a broad range of service roles within addiction treatment and allied health care, human service, and criminal justice agencies.
- Recovery support services are being rapidly privatized and professionalized—a trend with unclear long-term consequences.

### **Chapter Three: The Theoretical Foundations of Peer-Based Recovery Support**

- Some people who survive a life-altering disorder or experience develop special sensitivities, insights, and skills to help others similarly afflicted.
- The zeal recovering people bring to helping others reflects a deep sense of purpose and destiny, as well as a means of making amends for past addiction-related harm to others.
- Addiction counseling and peer recovery support rest on two overlapping, but potentially conflicting, traditions of authority: professional knowledge and experiential knowledge.
- The course and outcome of chronic illnesses are profoundly influenced by the peer support available to individuals and families who experience such illnesses.
- Exposure to the personal stories and lives of people in recovery can serve as a catalyst of personal transformation for people suffering from severe AOD problems.
- Peer recovery support helps to remedy the inequality of power/authority, perceived invasiveness, role passivity, cost, inconvenience, and social stigma associated with professional help for severe AOD problems.
- Peer helping is reciprocally beneficial: the helper and helpee both draw value from helping exchanges.

- In historically oppressed communities, hope for individuals and families is best framed within a broader vision of hope for a people, e.g., attaining social justice; addressing disparities in health, stigma, and discrimination; and widening doorways of community participation and contribution for all people.
- Understanding the ecology of recovery is crucial to the design of effective P-BRSS in all communities.
- P-BRSS provide experience-grounded guidance in the journey from cultures of addiction to cultures of recovery.
- As peer-based recovery support movements develop, they face twin risks: 1) anti-professionalism, “incestuous closure,” and implosion; and 2) loss of mission via the forces of professionalization, bureaucratization, and commercialization.
- All peer-based recovery support services rest on the primacy of personal recovery.
- P-BRSS constitute a mechanism of long-term recovery support that can enhance recovery outcomes at costs far less than those of services provided through sustained professional care.

#### **Chapter Four: Studies of the Effects of Participation in Recovery Mutual-aid Societies**

- Scientific studies regarding the effects of participation in recovery mutual-aid societies on long-term recovery outcomes are limited in scope and methodological rigor.
- Most of what is known about mutual-aid and recovery outcomes is based on studies of the effects of involvement in Alcoholics Anonymous by individuals treated in professionally-directed addiction treatment programs.
- Participation in recovery mutual-aid societies typically enhances long-term recovery rates, elevates global functioning, and reduces post-recovery costs to society among diverse demographic and clinical populations.
- Individual responses to recovery mutual-aid groups are variable, including those who respond optimally, those who respond partially, and those who fail to respond.
- Recovery mutual aid participation has multiple active ingredients, including motivational enhancement for recovery, reconstruction of

- personal identity, reconstruction of family and social relationships, enhanced coping skills, and the personal effects of helping others.
- The effects of recovery mutual aid involvement are interdependent with frequency, intensity, and duration of involvement.
  - Combining recovery mutual aid and professionally-directed addiction treatment has additive effects in clinical populations.
  - For clients in addiction treatment, affiliation with and benefits from recovery mutual-aid societies are influenced by counselor attitudes toward mutual aid, the style of linkage (assertive vs. passive, degree of choice, and personal matching), and the timing of linkage (during treatment vs. following treatment).
  - The Internet may provide an effective adjunctive or alternative delivery device for peer-based recovery support services.
  - The potential positive effects of recovery mutual-aid participation are often not achieved due to weak linkage procedures and high early dropout rates.

## **Chapter Five: Studies of the Effects of Participation in other Recovery Community Institutions**

- There is a long history of recovery support institutions beyond mutual-aid fellowships (e.g., recovery community organizations, Recovery Community Centers, recovery-oriented social networking sites, and other online resources), but very little research exists on the effects of involvement in these institutions on long-term recovery.
- Participation in recovery social clubs reduces the risk of relapse following addiction treatment.
- Living within the national network of Oxford Houses significantly reduces the risk of relapse and enhances long-term recovery outcomes.
- Participation in recovery high schools and college/university-based recovery communities reduces the risk of relapse, enhances recovery outcomes, and elevates academic achievement.
- Recovery industries and recovery-conducive employment sites have yet to be described or evaluated extensively in the scientific literature.
- Religion-oriented recovery colonies, recovery ministries, and recovery churches are growing but remain all but invisible to the professional addiction treatment and research communities.

- Recovery support structures organized by and for recovering people within the context of addiction treatment, such as consumer councils and alumni associations, have not been evaluated scientifically.

## **Chapter Six: Studies of Recovering People Working in Addiction Treatment**

- The portrayal of recovering people working in the addictions field is plagued by misconceptions and stereotypes that are contradicted by the available scientific evidence.
- The percentage of counselors in personal recovery within the specialty sector addiction treatment workforce has declined from nearly 70% in the early 1970s to approximately 30% in 2008.
- Recovery status alone does not predict pre-practice educational performance or performance on addiction counselor certification tests.
- Studies of addiction counselors in the United States have found that recovering addiction counselors are *as* effective as counselors who are not in recovery, with neither group showing superiority based only on the question of recovery status.
- The key determinants of effectiveness do not include recovery status. The effectiveness of counselors in personal recovery, like that of counselors not in recovery, varies widely from person to person.
- Recovering people working in addiction treatment are paid less than people not in recovery for comparable work, even when their educational credentials are equal.
- Studies of the personalities of recovering men and women working as addiction counselors reveal few differences from counselors without addiction recovery backgrounds.
- Much of what has been attributed to recovering counselors by way of beliefs and attitudes is a function of educational level; as educational levels of people in recovery have increased, differences between recovering counselors and counselors without addiction histories diminish or disappear completely.
- Attitudes toward evidence-based practices differ by educational levels but not by recovery status (when education levels are controlled).
- People in recovery do not constitute a homogenous group: attitudes/beliefs, clinical effectiveness, and the quality of ethical sensitivity and decision-making cannot be predicted based on recovery status.

- Studies of the relapse rates of recovering addiction counselors over the past 40 years report relapse rates ranging between 5% and 38%, with rates progressively declining through these years.
- The evaluation of treatment models delivered primarily by counselors in personal recovery report recovery outcome rates similar or superior to those of programs whose services are delivered by counselors without recovery backgrounds.
- Volunteer programs in addiction treatment relying primarily on volunteers in personal/family recovery have been evaluated positively; volunteer programs declined in popularity within the field throughout the 1980s and 1990s but are increasing in tandem with renewed calls for peer-based recovery support services.

### **Chapter Seven: Recent Studies of Recovery Coaching and P-BRSS**

- There are currently two federal programs administered by the Center for Substance Abuse Treatment that fund initiatives that emphasize peer-based recovery support services: the Recovery Community Services Program (RCSP) and the Access to Recovery (ATR) Program.
- Studies have not been conducted to determine the effects of RCSP or ATR services on long-term recovery outcomes.
- There are independent studies of particular peer-based recovery support services that have been linked to enhanced engagement, access, treatment completion, and improved long-term recovery.

### **Chapter Eight: A P-BRSS Research Agenda**

- There are increased calls for a recovery-focused research agenda capable of illuminating the prevalence, pathways, styles, and stages of long-term individual/family recovery from severe AOD problems.
- Research on naturally occurring recovery communities is best conducted with the sensitivities and methods recently developed for the study of other ethno-cultural communities.
- A research agenda related to P-BRS and P-BRSS must encompass expanded research on the effectiveness of recovery mutual-aid societies (particularly non-12-Step recovery support groups); the role of other recovery community support institutions in long-term recovery; the influence of recovery representation at board, executive,



staff, and volunteer levels on recovery outcomes of service consumers; individual factors affecting the degree of effectiveness of P-BRSS; the effectiveness of particular P-BRSS across the stages of recovery; the relative potency of key recovery support service ingredients; the relationship of P-BRSS to professional treatment; the effects of P-BRSS on family health and functioning; and the influence of organizational context on the effectiveness of P-BRSS.

- Research should also identify the major sources of resistance to P-BRSS and the most effective methods of implementing P-BRSS.
- The recovery research agenda must encompass studies of recovery at individual, family, and community levels.

## **Chapter Nine: Summary and Conclusions**

Specialized addiction treatment grew out of the failure of the mainstream health and human service system to provide effective solutions for individuals and families experiencing alcohol and other drug problems. Today, peer-based recovery support services are growing out of the failure of professionally-directed addiction treatment to provide a continuum of care that is accessible, affordable, and capable of helping people with the most severe and complex AOD problems move beyond brief episodes of recovery initiation to stable long-term recovery. P-BRSS are specifically designed to reach people earlier in their addiction careers, enhance recovery initiation and stabilization, improve linkage to recovery mutual-aid groups and other recovery support institutions, facilitate the transition to successful recovery maintenance, and enhance the quality of personal and family life in long-term recovery.

However, this model is not a panacea. We would do well to avoid the superficial infatuation with P-BRSS that marked the infatuation with recovering alcoholics and ex-addicts in the late 1960s and early 1970s in the rise of modern addiction treatment. The value of P-BRSS is found in identifying what those in recovery specifically bring to the helping process.

Peer-based models of care can have a transforming effect on larger systems of care and on our society by enhancing long-term addiction recovery outcomes and elevating public and professional perceptions of hope for recovery. However, peer models of recovery support can also be corrupted and devoured by larger systems of care. As peer-based services are integrated into the existing treatment system or offered by free-standing independent organizations, there will be pressure to emulate the ethos of the

existing treatment system, including the professional roles of counselors and others.

At the dawn of modern addiction treatment, observers suggested that one of the advantages ex-addict counselors brought to their role was that they were “unencumbered by ‘professionalism’ and entanglement in bureaucracy” and were free to “interact with patients in a less formal, more spontaneous fashion than professionals” (Suchotliff & Seligman, 1974). Care must be taken not to over-professionalize P-BRSS roles and replicate the very conditions out of which these peer-models were spawned. It will be very important to achieve a delicate balance between peer-based and professional service models, to retain the strengths of each, and manage the vulnerabilities inherent in each model.

Delivering P-BRSS can enrich an individual’s own recovery experience, but this work can also be a threat to one’s sobriety. In P-BRSS models, service accessibility, availability in time of crisis, and continuity of contact over time constitute distinctive strengths, but they also provide a potential source of over-extension and burnout for individual workers and their organizations. There is an inevitable strain between accessibility and stewardship of resources as organizations providing P-BRSS define their recovery support capacity (How many people? How many services? How long?). P-BRSS are based on the power of mutual identification—a relationship that is personal, reciprocal, and prolonged—but these same traits are potential sources of boundary ambiguity, abuse of power, and moving beyond the boundaries of personal competence. That is why training, guidelines, and supervision are as important for P-BRSS as for professional services.

Rather than view peer-based and professional-based styles of knowing and doing as antagonistic models that must be judged against one another in terms of superiority and inferiority, it is more helpful to view these approaches as complementary, what one of the field’s pioneers referred to as a “creative fusion of heart and mind” (McGovern, 1992).

Peer-based recovery support services can help shift the larger treatment system from a focus on brief biopsychosocial stabilization to a focus on the long-term recovery process. Peer-based models can inject a recovery focus—a source of renewal—into treatment institutions whose fear of the current climate of financial scarcity has driven them into excessive preoccupation with paper, profit, and professional prestige. P-BRSS specialists can help divert excessive attention from “funding streams,” “product lines,” and “bottom lines” and refocus attention on long-term recovery pathways and processes for individuals and families. This must be

done in a way that avoids the “us and them” polarizations between peer and professional models of recovery support.

The addictions field brings one unique quality that separates it from peer models that are rising in allied fields. It has the oldest and largest recovery mutual aid network in the world via the growth of spiritual, secular, and religious recovery mutual-aid groups and new recovery support institutions. We must be very careful that new peer-based models capitalize upon the strength of these communities of recovery rather than undermining or replacing them. Our long-term goal is not to create a larger treatment system or a new profession, but to create the physical, psychological, and social space in which recovery flourishes in local communities.

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## References

- Hughes, H. (1974, December). *Address before the North American Congress on Alcohol and Drug Problems*. San Francisco, CA.
- McGovern, T. (1992). Alcoholism and drug abuse counseling: A personal reflection. *The Counselor, 10*(3), 38-46.
- Suchotliff, L., & Seligman, E. (1974). The myth of the ex-addict staff. *Drug Forum, 4*(1), 47-51.