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**The History and Future of Peer-based Addiction Recovery Support Services  
(Executive Summary)**

William L. White, MA

**History** Within the addictions arena, there is a long and rich history of recovery mutual aid societies, peer-based recovery support groups, and the use of recovered/recovering people in paid service roles from which lessons can be drawn.

**Origin** Peer-based recovery support services (P-BRSS) are emerging from:

- research confirming the limitations of existing treatment models,
- calls to reconnect treatment to the more enduring process of addiction recovery,
- a shift from pathology and treatment paradigms to a recovery paradigm, and
- a shift from acute care to models of sustained recovery management.

**Rationale** Peer-based service models are based on sound psychological principles, have been tested in multiple environments (including addiction treatment settings), and are grounded in the aspirational values of local communities of recovery.

**Issues** Critical issues in the design and implementation of P-BRSS services include:

- questions of power and control (e.g., who gets to define peer?);
- the variability and lack of empirical testing of P-BRSS models;
- P-BRSS role and definitions and credential requirements;
- the multiplicity of role demands placed upon the P-BRSS specialist;
- adapting P-BRSS to emerging knowledge on the pathways, styles and stages of long-term addiction recovery; and
- integrating P-BRSS with the treatment continua of care and linking P-BRSS to indigenous recovery support structures.

**Benefits and Risks** Theorized benefits of P-BRSS will require empirical validation, and care will be needed to avoid unintended harm of P-BRSS to service consumers, service providers, service organizations and local communities of recovery.

**Obstacles** There are conceptual, emotional, technical, administrative and fiscal obstacles that will have to be overcome before P-BRSS services emerge as a widely available resource in American communities.

**Recommendations** Action recommendations include:

- Develop national and state recovery support infrastructures that span inter-related problems (addiction, mental illness AIDS) and serve as a resource for the development of local P-BRSS
- Develop models of successful collaboration between P-BRSS, indigenous mutual aid groups, professionally-directed addiction treatment services, and other health and human services
- Develop ethical and relationship guidelines for the delivery of P-BRSS
- Conduct controlled studies (multi-site randomized clinical trials) that evaluate the long-term effects of P-BRSS on recovery outcomes and the impact of P-BRSS on indigenous recovery support groups and the larger community.

P-BRSS models could be a superficial appendage to the treatment system or an instrument that triggers the broader transformation of that system. P-BRSS services will be a boon if they widen the doorways of entry into recovery and enhance recovery quality and durability. If P-BRSS models inadvertently lead to the commercialization and erosion of the service ethic within communities of recovery and an ever-growing recovery support services industrial complex, this experiment will have failed horribly.

# The History and Future of Peer-based Addiction Recovery Support Services

William L. White, MA<sup>1</sup>

## Introduction

The intent of this paper is to outline issues and recommendations related to the design, development, and evaluation of peer-based<sup>2</sup> recovery support services (P-BRSS) within the addictions field. Two introductory points are warranted. First, exploring P-BRSS requires use of a recovery-oriented language that has been defined in the text, within footnotes, or defined and discussed in a published recovery glossary (White, 2002a) posted at [www.bhrm.org](http://www.bhrm.org). Second, the necessity to tightly condense complex ideas within this paper calls for encouragement of the reader to further explore the cited and recommended resources.

## Background

History of Addiction Recovery Mutual Aid<sup>3</sup> Societies Addiction recovery mutual aid societies have a rich history spanning 18<sup>th</sup> and 19<sup>th</sup> century Native American “recovery circles” (abstinence-based healing and religious/cultural revitalization movements), the Washingtonians (1840s), fraternal temperance societies (1840s-1870s), ribbon reform clubs (1870s-1890s), Drunkard’s Club (1870s), United Order of Ex-Boozers (1914), Alcoholics Anonymous (AA) (1935), Alcoholics Victorious (1948), Narcotics Anonymous (1953) and other Twelve-Step adaptations, adjuncts to AA (Calix Society, JACS), alternatives to AA (e.g., Women for Sobriety, Secular Organization for Sobriety, LifeRing Secular Recovery), the Wellbriety Movement in Indian Country, and faith-based recovery ministries (particularly within African American communities) (White, 1998, 2001a; Coyhis & White, 2002; Sanders, 2002).

History of Peer-based Social Support Linked to Addiction Treatment Peer-based social support linked to addiction treatment institutions span patient clubs developed within inebriate homes and asylums (Ollapod Club, the Godwin Associations) and addiction cure institutes (Keeley Leagues)(1860s-1890s), the Jacoby Club of the Emmanuel Clinic in Boston (1910), AA “wards” (in hospitals) and “farms” (1940s-1950s), halfway houses (1950s) and self-managed recovery homes (e.g., Oxford Houses),

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<sup>1</sup> William White, the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, is a Senior Research Consultant at Chestnut Health Systems and Associate Director of the Behavioral Health Recovery Management project. He has served on the boards of Recovery Communities United, the Alliance for Recovery, and Wellbriety for Prisons, Inc., and provided consultant to numerous recovery advocacy and recovery support organizations.

<sup>2</sup> The term “peer” is used here rather than “consumer.” The latter implies support services provided by someone who is or has been a recipient of professionally-directed treatment services. In the addictions arena, recovery support services may be provided by persons in recovery, or otherwise defined as an ally by those receiving help, who have not been “consumers” of treatment services. Use of the term “peer” rather than “consumer” reinforces that there are multiple pathways to recovery, not all of which involve professionally-directed addiction treatment, and affirms an identity linked to a community of recovering people rather than a treatment institution.

<sup>3</sup> These groups are here referred to as “mutual-aid” groups rather than “self-help” groups as they technically are not self-help, but an admission that efforts at self-help are exhausted, requiring a reliance on resources and relationships that transcend the self (Miller & Kurtz, 1994).

treatment program volunteers, California's "social model" programs,<sup>4</sup> treatment center "alumni associations," and new peer-based support models developed by the Center for Substance Abuse Treatment's Recovery Community Support Program grantees (White, 1998, 2001a).

History of Paid Peer Helpers The use of paid peer helpers (people in recovery hired to serve as guides for others seeking recovery) in the addictions arena spans recovered and recovering<sup>5</sup> people working as temperance missionaries (1840s-1890s); aides ("jag bosses") and managers of inebriate homes (1860s-1900); Keeley Institute physicians (1890-1920); "friendly visitors" within the Emmanuel Clinic in Boston (1906); lay alcoholism psychotherapists (1912-1940s); managers of "AA farms" and "AA rest homes" (1940s-1950s); halfway house managers (1950s); "paraprofessional" alcoholism counselors and professional "ex-addicts" (1960s-1970s); credentialed addiction counselors; detox technicians, residential aids, outreach workers, and case managers (1970s-1990s), and, more recently, "recovery coaches," "recovery mentors," and "recovery support specialists" (White, 1998, 2000c). There are states (CT, AZ) that are working to systematically include P-BRSS as part of a reconfigured continuum of addiction treatment services care and at least one state (PA) that is already investigating the credentialing of recovery support specialists.

Geographical Range Addiction recovery mutual aid groups and peer-based support models are an enduring international phenomenon reflected in the international growth of AA and NA and in such recovery mutual aid movements as the Blue Cross (Switzerland, 1877), the Kreuzbund (Germany, 1885), Croix d'Or (France, 1910), Zukunft/Abstinence Union (Austria, 1926), Swedish Links (1945), Vie Libre (France, 1953), Polish Abstainers Club (1960), the Danshukai movement (Japan, 1963) and the Pui Hong Self-Help Association (China, 1967) (Humphreys, 2004; White, in press).

Conditions Spawning P-BRSS Historically, addiction-related P-BRSS have been sparked by the:

- inadequacies of professionally-directed interventions (the failure to consistently provide recovery-oriented services characterized by accessibility, affordability, quality and continuity of support)
- failure to fully legitimize and facilitate multiple (including gender-specific, culturally-nuanced, medication-assisted) pathways of entry into recovery, and the
- belief that treatment has become disconnected from the larger, more enduring and socially-mediated process of addiction recovery (White, 2001b; 2002b; 2003a; 2003b).

As peer-based services seek to link themselves to the existing treatment system, there will be pressure to emulate the treatment system and its professional roles. Great care must be taken to preserve that which is unique and authentic within P-BRSS.

Rationale P-BRSS in the addictions arena are based on the following propositions:

- Helpers derive significant therapeutic benefit from the process of assisting others (the "helper principle") (Reisman, 1965, 1990; recovery slogan: "To get it, you have to give it away.").

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<sup>4</sup> See special issue of *Journal of Substance Abuse Treatment* Volume 15, Number 1, 1998.

<sup>5</sup> See White, 2002a for the distinctions between these two terms.

- People who have overcome adversity can develop special sensitivities and skills in helping others experiencing the same adversity--a “wounded healer” tradition that has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements.
- The inadequacy of acute care models of treatment for people with high problem severity and complexity is evident in low engagement rates, high attrition rates during treatment, low aftercare participation, and high re-admission rates.<sup>6</sup>
- Persons with high personal vulnerability (family history, low age of onset of use, traumatic victimization), AOD problem severity and complexity (co-morbidity) and low “recovery capital”<sup>7</sup> do not fare well in acute models of intervention but can achieve recovery when provided sustained support. (P-BRSS constitute an essential element within new models of sustained recovery management) (White, Boyle and Loveland, 2002, 2003).<sup>8</sup>
- Many addicted people benefit from a personal “guide” who facilitates disengagement from the culture of addiction and engagement in a culture of recovery (White, 1996).
- Peer-based recovery support relationships that are natural, reciprocal, and enduring are not mutually exclusive of, but qualitatively superior to, relationships that are hierarchical, commercialized and transient.
- P-BRSS are an attempt to re-link treatment and recovery (Else, 1999; White, 2000b), to move the locus of treatment from the treatment institution into the natural environment of those seeking treatment services (White, 2002a), and to facilitate the shift from toxic drug dependencies to “prodependence on peers” (Nealon-Woods, et al, 1995).

P-BRSS services are congruent with research findings that<sup>9</sup>:

- Addiction recovery begins prior to the cessation of drug use; is marked in its earliest stages by extreme ambivalence; is sustained long after the period of initial stabilization of sobriety; involves different types of age-, gender-, and culture-mediated change processes; and is often marked by predictable stages of change.
- The achievement of stable recovery is determined, in part, by recovery capital that can be enriched through support services.
- Factors that sustain recovery are different than those that initiate recovery.
- Push factors (pain) and pull factors (hope) both play a role in the recovery process; P-BRSS have a direct effect on the latter.

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<sup>6</sup> In 1999, 1,346,759 people were admitted to publicly funded treatment, 58% having been in treatment before (23% once, 23% two to four times, and 12% five or more times) (Office of Applied Studies, 2001).

<sup>7</sup> Recovery capital is the total amount of internal and external resources that an individual, family or community can bring to bear on the initiation and maintenance of recovery (Granfield & Cloud, 1999).

<sup>8</sup> RM models will fundamentally change P-BRSS linked to addiction treatment. The addictions field has a long history of employing former clients in service roles, but RM’s shift to prolonged, low intensity recovery supports will mean that addiction treatment agencies, like their mental health counterparts, will be potentially hiring some persons who currently receive services at the agency, making them both service consumers and service providers. The ethical/boundary issues raised by such role duality are numerous and complex. The successful ways such issues are being managed in the mental health field and AIDS service community offer a source of fruitful collaboration.

<sup>9</sup> See White, Boyle, Loveland (2002) for a review and citations.

- The point at which most recoveries become fully stabilized is between four and five years—suggesting the need for a system of sustained monitoring and support.
- Long-term recovery is mediated by processes of social support.

An extensive body of research suggests the potential effectiveness of peer-facilitated models of change (Durlak, 1979; Hattie, et al, 1984; Riessman, 1990), particularly within the arena of addiction recovery (Connett, et al, 1980; Galanter, et al, 1987; Blum and Roman, 1985).

Values Values governing P-BRSS should be extracted from a larger set of values guiding a “recovery-oriented system of care” (For sample, see <http://www.dmhas.state.ct.us/corevalues.htm>). Values that have been emphasized within the deliver of P-BRSS within the addictions arena include a focus on potential (strengths, resilience) rather than problems (pathology), empowerment rather than paternalism, a respect for diverse pathways and styles of recovery, a preference for voluntary versus coerced participation, a focus on wellness/wellbriety/global health versus a singular focus on abstinence, involvement (of recovering people in P-BRSS policy development), inclusiveness (reaching out to multiple ethnic/religious/recovery communities), the need to confront stigma at personal and cultural levels, and the need to integrate clinical and advocacy/community development models that focus on the ecology of recovery (enriching recovery capital within families, communities, and nations) as well as the personal dynamics of recovery. Overriding all of these is the primacy of recovery: the quality of P-BRSS to others is contingent upon the quality of one’s own recovery.

### **Key Issues and Discussion**

Definition of “Peer” A most critical issue in the design and delivery of P-BRSS is the question of who defines *peer*. There is growing consensus that it is the right of recipients of P-BRSS services to define *peer*. *Peer* is most often defined in terms of recovery status (knowledge of recovery from the inside—as a recovering person or family member or someone vetted inside the community as having expertise as a recovery guide). It may also include qualities essential to the service alliance (e.g., shared gender, ethnicity, religious orientation, developmental experiences, or accountabilities to the same community).

Peer Credentials Persons providing P-BRSS, rather than being legitimized through traditionally acquired education credentials, tend to be legitimized based on *experiential knowledge* and *experiential expertise* (Borkman, 1976). It is not the experience of having been wounded or having transcended such wounds that constitutes a credential. It is the extraction of lessons from that experience (distinguishing the universal from personally unique aspects of recovery) that can aid others, and a new ethic that transforms that learning into service to others. Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. Experiential expertise requires the ability to use this knowledge to affect sustainable change in self or others. It requires the ability to separate the experience of the helper from that of the person being helped. The dual credentials of experiential knowledge and experiential expertise are granted through the addiction/recovery community “wire”/“grapevine” via storytelling. It is bestowed only on those who offer

sustained living proof of their expertise as a recovery guide within the life of the community (White & Sanders, forthcoming).

P-BRSS Model Variations P-BRSS may be delivered within a clinical model (that views the recovery support specialist as a treatment aide) or a community development model (that views the support specialist as an organizer and mobilizer of community recovery resources). P-BRSS services may be delivered within an acute care (AC) model of treatment (crisis intervention, clinical stabilization, and recovery initiation) or within a model of recovery management (RM) models that emphasizes a more sustained continuum of pre-recovery, recovery initiation and recovery maintenance support services. RM models are particularly distinguished by sustained recovery monitoring (including recovery checkups), stage-appropriate recovery education, active linkage to indigenous communities of recovery, and early re-intervention (White, Boyle & Loveland, 2002,2003). P-BRSS services can be based on a pathology model (focus on solving problems) or on a strengths (resistance/resiliency/wholeness) model (focus on building recovery capital within the individual, family and community). P-BRSS services may be delivered as an adjunct to other service roles (e.g. counselor, case manager, or outreach worker) or may be delivered within a specialized paid or volunteer role. P-BRSS services may be delivered within existing treatment institutions, delivered by other local community institutions (church, school, labor union) or delivered by a grassroots recovery advocacy or recovery support organization.

Types of P-BRSS (Service Menu) The range of services provided with the framework of P-BRSS is indicated by the broad range of roles being proposed within “recovery coach” pilot studies. The recovery coach is a:

- motivator and cheerleader (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement)
- ally and confidant (genuinely cares, listens, and can be trusted with confidences)
- truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting)
- role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice)
- problem solver (identifies and helps resolve personal and environmental obstacles to recovery)
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support)
- advocate (helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights)
- community organizer (helps develop and expand available recovery support resources)
- lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living)
- a friend (provides companionship).

Equally important, the P-BRSS specialist is NOT a:

- sponsor (does not perform AA/NA service work on “paid time”)
- therapist (does not diagnose, probe undisclosed trauma/“issues”; does not refer to their support activities as “counseling” or “therapy”)

- nurse/physician (does not make medical diagnoses or offer medical advice), or a
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church)<sup>10</sup>.

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

P-BRSS and Pathways of Recovery P-BRSS services are best delivered within the recognition of multiple long-term pathways of recovery (White, 1996). The practical implications of this proposition is that the recovery support specialist must:

- recognize the legitimacy of these multiple pathways
- become conversant with the language, catalytic metaphors<sup>11</sup> and rituals reflected within these pathways
- work to expand the variety of recovery support structures within the communities he or she serves, and
- develop relationships with the myriad groups representing these pathways.

P-BRSS and Style of Recovery P-BRSS are best delivered within the recognition of multiple styles of recovery. Such style variations are reflected in the recovery process (transformative change<sup>12</sup> versus incremental stages of change), identity reconstruction (recovery-positive versus recovery-neutral identity), and post-recovery interpersonal relationships (acultural, bicultural and culturally enmeshed styles of recovery)(White, 1996). The operational motto of the best P-BRSS specialists is “recovery by any means necessary.” It matters little to them whether recovery is initiated without professional assistance (solo or natural recovery), with peer-assistance or professional treatment (affiliated or assisted recovery), or is initiated via peer and professional supports but maintained without such assistance (disengaged recovery) (White, 2002a). The focus is on the goal, not the method. Such tolerance and respect requires maturity and wisdom.

P-BRSS and Stages of Recovery P-BRSS services (particularly within recovery management models) are based on the following assumptions:

- There are predictable stages in the long-term process of addiction recovery.
- Service and support services that are crucial in one stage may be unhelpful or even harmful at another stage.
- Service and support needs must be continually reassessed via sustained dialogue with the person in recovery (monitoring, assessment of recovery quality and stability, recovery plan refinement).

P-BRSS and the Existing Continuum of Treatment The current addiction treatment continuum of care that focuses on crisis intervention and recovery initiation needs to be reconfigured with pre-treatment recovery support services, in-treatment recovery support

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<sup>10</sup> P-BRSS specialists draw from an eclectic menu of religious and secular concepts and metaphors to anchor the recovery process.

<sup>11</sup> Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite change in beliefs, behavior, identity and relationships.

<sup>12</sup> Transformative change is characterized by its suddenness, vividness, positiveness and permanence (Miller and C’de Baca, 2001).



services (to enhance engagement and reduce attrition) and post-treatment monitoring and stage-appropriate support services. The emphasis is on the transfer of institutional learning and anchoring recovery within the natural environment of the client. There is a danger that P-BRSS will evolve as a separate system disconnected from the national network of addiction treatment programs. B-PRSS are coming out of a new generation of grassroots recovery advocacy and support organizations who perceive many treatment programs as more concerned about their own institutional interests than the long term recovery outcomes of those they serve. This undercurrent of disenchantment and hostility and its sources will need to be openly confronted and resolved if the goal of a system of integrated clinical treatment and recovery support services is to be achieved. Lacking such resolution, the proliferation of P-BRSS and their alienation from mainstream treatment could further fragment a system that is already difficult to navigate. The following principles are suggested as a foundation for such collaboration.

- P-BRSS and professionally-directed addiction treatment services are complimentary rather than competitive.
- P-BRSS and TX services must be integrated into a single, seamless continuum of services.
- P-BRSS specialists and treatment specialists must recognize and respect the special contributions each can make to the recovery process.
- Both P-BRSS specialist and treatment specialists must accurately represent and practice within the boundaries of their education, training and experience.<sup>13</sup>
- The goal is to have all services—professional and peer--become person-oriented, family-oriented and recovery-oriented.

P-BRSS and Existing Sobriety-Based Support Groups The effects of P-BRSS on existing recovery mutual aid societies is unknown. There is reason to believe that such services will increase engagement and reduce attrition within such societies and that organizations providing P-BRSS services will find ways of developing working relationships with such groups, but harm to such groups could flow from P-BRSS (See below discussion).

Strengths and Vulnerabilities of P-BRSS Models P-BRSS services will require extensive evaluation to determine their effects on addiction and recovery careers. There will be particular interest in how P-BRSS can enhance the effectiveness of the existing treatment system. Testing the following hypotheses would be a good starting point for such research. P-BRSS services can:

- increase the number of people entering addiction treatment
- decrease the number of people “lost” from waiting lists to enter addiction treatment
- divert individuals with lower problem severity and higher recovery capital into natural recovery support systems in the community (creating a better stewardship of limited treatment resources)
- enhance treatment retention and completion

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<sup>13</sup> This must be based on mutual respect and the recognition that some services are best provided by traditionally trained professionals while others are best provided by peer specialists. The expectation of respect for boundaries of competence applies to both roles.

- increase post-treatment abstinence outcomes
- delay the time period from discharge to first use following treatment (enhancing development of recovery capital)
- prevent lapses from becoming relapses
- shorten the number, intensity, and duration of relapse episodes following treatment
- decrease treatment readmission rates (slow the revolving door of treatment)
- decrease the time between relapse and re-initiation of treatment and recovery support services (preserving recovery capital and minimizing personal and social injury)
- result in readmission to less intensive, expensive levels of care
- reduce attrition in first year affiliation rates with AA and other sobriety-based support groups
- enhance recovery capital (e.g., employment, school enrollment, stable housing, healthy family and extended family involvement, sobriety-based hobbies, financial resources) and self-defined quality of life.

At a systems level, P-BRSS offer an opportunity to enhance linkages between the existing treatment agencies and local indigenous recovery support systems—linkages that have eroded through the commercialization of addiction treatment. P-BRSS roles may also offer an opportunity to retrieve the best of what was lost on the road to professionalizing the role of addiction counselor, e.g., a service relationship based on moral equality, practical recovery coaching, knowledge of and active linkage to local communities of recovery.

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

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

Potential Iatrogenic Effects of P-BRSS The history of addiction treatment is filled with iatrogenic insults (treatment-caused harm or injury)<sup>14</sup>, and the potential for such effects with P-BRSS requires active prevention and management.

*Risk to Service Consumers* Consumers of recovery support services could be injured from incompetent care and through boundary violations (financial, emotional, and sexual exploitation) in their relationships with P-BRSS service specialists. P-BRSS may require a set of protections analogous to those provided upon entry to addiction treatment (e.g., credentialing, codified ethical standards and complaint procedures, informed consent, confidentiality, clinical supervision).

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

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

*Risk to the Community* P-BRSS could also injure the larger recovery community by engendering conflict about such services within mutual aid organizations and by undermining or commercializing the service ethic within such organizations. The goal of P-BRSS services is to exponentially expand natural recovery support services within each community, not replace voluntary support services with paid services. If the result of P-BRSS services is the latter, the harm will be a significant one. If five years following the implementation of P-BRSS a community has more paid peers but fewer sponsors and weaker sponsorship rituals within AA/NA and other mutual aid societies, then the P-BRSS model will have failed horribly.

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<sup>14</sup> Such iatrogenic insults include mandatory sterilization, indiscriminate application of chemical and electroconvulsive therapy, harmful drug therapies, prolonged sequestration, profane confrontation and humiliation, and financial exploitation, to name a few.

Implementation Obstacles The barriers to implementing P-BRSS are substantial and span obstacles that are:

- conceptual (failure to see the need for P-BRSS services; conflicts between the P-BRSS emphasis on the ecology of recovery / recovery community building and traditional biopsychological models of problem intervention)
- emotional (failure of traditionally-trained professionals to accept P-BRSS service specialists as legitimate professional peers)
- technical (lack of empirical models of P-BRSS and P-BRSS implementation protocol)
- administrative (challenges complying with treatment-oriented licensing and reporting procedures), and
- fiscal (lack of financing models for P-BRSS, cuts in treatment-related services due to state fiscal austerity).

Evaluation of Peer-Based Services The evaluation of P-BRSS is part of a larger recovery research agenda within the addictions arena—an arena that has amassed considerable research on the nature of psychoactive drugs and addiction and the effects of treatment, but which knows very little about the prevalence and processes of long-term addiction recovery. The evaluation of P-BRSS services needs to be encompassed in the larger agenda of charting the long-term pathways, styles and stages of recovery and the processes that mediate full and partial recovery. P-BRSS need to be subjected to rigorous scientific evaluation, but their evaluation should also be conducted by recovery community elders addressing the question, “What has our experience taught us about the short- and long-term effects of P-BRSS services on individuals, families, and local communities of recovery?”

## **Action Items and Recommendations**

### Recovery Support Infrastructure

- Establish a National Recovery Resource Center to serve as a clearinghouse for recovery research, recovery support models, and P-BRSS-related training and consultation services (The Center’s mission should span recovery from overlapping problems areas--addictions, mental health, AIDS.)
- Provide opportunities for representatives from local P-BRSS organizations to assemble regionally and nationally and to participate in an internet-based system of information exchange
- Support the development and quality of P-BRSS services via development and dissemination of concept papers, organizational tools (how to create a P-BRSS organization and work with a local P-BRSS board; how to develop P-BRSS within an existing treatment agency), role qualifications and hiring procedures, sample grant proposals, model service protocol, etc.<sup>15</sup>
- Explore development of P-BRSS services as a formally recognized level of care within the American Society of Addiction Medicine’s Patient Placement Criteria for the Treatment of Substance-related Disorders

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<sup>15</sup> What I am calling for here is the development of resources similar to those that have been beneficial to the mental health consumer/survivor movement, e.g., Mowbray, C., Moxley, D., Jasper, C. and Howell, L. (1997) *Consumers as Providers in Psychiatric Rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

- Develop models for the funding and reimbursement of recovery support services, assessing both the advantages and problems (e.g., over-professionalizing P-BRSS; drowning P-BRSS in paper and procedures) associated with particular models
- Make federal funding of addiction treatment agencies contingent upon inclusion of or linkage to P-BRSS and inclusion of recovered/recovering individuals/family members on their policy-making boards
- Conduct a special exploration of the potential of P-BRSS for persons involved in methadone maintenance treatment (MMT), including an exploration of how the social and professional stigma associated with MMT (even within the worlds of addiction treatment and recovery) have slowed the development of MMT-related P-BRSS and how such services might be particularized to that setting

#### Model Definition, Development, and Dissemination

- Create local venues in which “peer” qualifications can be defined and values and standards developed that can guide the delivery of P-BRSS
- Poll P-BRSS organizations to evaluate the pros and cons of credentialing P-BRSS roles and to discuss such issues human resource issues as compensation scales, benefit modifications, career ladders, etc.
- Develop model support procedures for the transition from person in recovery to peer service specialist, e.g., P-BRSS orientation and training curricula
- Develop supervisory protocol for P-BRSS procedures that address such issues as relationship boundary management, safety management, the fragile balance between service responsiveness and self-care, and that address issues raised in supervision from an employee development framework rather than a therapeutic framework
- Develop model policies and protocol for responding to impairment (e.g., lapse/relapse) of peer specialists
- Define processes through which organizations providing P-BRSS can articulate organizational values (equivalent to AA’s Twelve Traditions) that can guide programmatic and service decision-making and guide the organization’s relationship with local communities of recovery
- Extract (from accumulating experience) different models of linking P-BRSS services to particular levels of care within the existing system of addiction treatment
- Pilot, evaluate and disseminate the findings of open-ended (designed to rapidly evolve in response to changing consumer needs and accumulated experience) P-BRSS initiatives in different cultural and geographical contexts, different institutional settings, and with different demographic and clinical subpopulations

#### Models of Collaboration

- Develop and disseminate case studies and models of successful collaboration that integrate P-BRSS, support provided by indigenous mutual aid groups, professionally directed addiction treatment services, and other health and human services
- Develop models of collaboration between mutual aid service structures (Central Offices, Intergroups, H & I committees, etc.) and P-BRSS organizations/units

#### Ethics of P-BRSS

- Convene a national meeting of P-BRSS organizations across problem arenas (addictions, mental health, AIDS) to define a process/model through which local programs can define core values and practice codes to guide the delivery of P-BRSS
- Collect and distribute statements of values and practice standards emerging from local P-BRSS programs
- Develop an ethics casebook that can be used in the training of P-BRSS specialists (For prototype, see White & Popovits, 2002).

#### Evaluation

- Locate and celebrate exemplary models in which service consumers play a central role in the evaluation of services
- Conduct controlled studies (multi-site randomized clinical trials) that evaluate the long-term effects of P-BRSS on recovery outcomes.
- Conduct cost studies on the ability of P-BRSS to reduce hospitalization and arrest/incarceration rates, reduce the number and duration of addiction treatment episodes and generate measurable recovery capital (e.g., employment).
- Conduct qualitative evaluations of the impact of P-BRSS on indigenous recovery support structures and the larger community.
- Evaluate the impact of organizational setting (peer-founded and controlled organization, peer employees as a component of addiction treatment or other community organization); funding scheme (government funding versus private funding versus voluntary); role construction (recovery support services as specialized role versus a function within existing roles; paid versus volunteer recovery support specialists), and P-BRSS philosophy (medical, social, cultural, religious, liberationist) on the outcomes of peer-based services.

The current system of addiction treatment is in need of redesign and renewal. P-BRSS could become a superficial (token) appendage to this system or it could become an instrument that sparks a wider transformation of that system. P-BRSS could help shift the addiction treatment system from serial episodes of self-encapsulated acute care to a model of sustained recovery management. So typical of the many paradoxes of recovery, addiction treatment as a system of care might well be redeemed by those for whom it was originally designed to serve.

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