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## **Reflections on Two Decades of Recovery Advocacy and the State of Recovery Support Services: An Interview with Tom Hill**

William L. White

### **Introduction**

In documenting the modern history of recovery advocacy and peer recovery support services in the United States, I have had the opportunity to collaborate with some extremely talented and charismatic figures – folks I have christened *recovery carriers* because of the contagious energy emanating from their story and the quality of their lives and service work. One such individual I have admired since our first meeting is Tom Hill. We have shared ideas, shared speaking lecterns, and marched side-by-side in recovery celebration events for more than a decade. Tom is in a unique position to reflect on the history of recovery advocacy and peer recovery support services in the United States. He is among the handful of people who have worked full-time in these arenas since their origin in the late 1990s, and the multiple roles he has filled afford a distinctive vantage point on the evolution of recovery advocacy and support. In the late fall of 2011, I asked Tom to share his thoughts about the new recovery advocacy movement and the state of recovery support services in the United States. Please join us in this engaging conversation.

### **Early Advocacy Activities**

**Bill White:** Tom, you began your formal role as a recovery advocate as Project Director of Speak Out. How did that opportunity come about?

**Tom Hill:** I got sober in 1992, and after hovering around the closet door for several years, an important part of my sober experience was coming out as a gay man. Coming out as a gay man in New York City in 1992 meant that I entered a sober gay community but also one fraught with HIV/AIDS. This was before the protease inhibitor cocktail came out, so an HIV diagnosis was pretty much a death sentence. The community was very mobilized, and part of my coming out and being sober was joining an activist community centered around groups like ACT UP.

Through that process, I became engaged in community organizing and activism, and that led me to go back to graduate school to study community organizing in a social work program at Hunter College. My life changed dramatically in terms of my career. I'd previously been an artist, and in early recovery, I was learning and growing in all kinds of new ways. When I was in graduate school, one of my internships was with the public policy department at the LGBT Community Center. After graduating, I got a job running an LGBT Senior Center in Queens, and Barbara Warren, who worked at the Center in New York, asked me if I wanted to work for this new program that the center had gotten a federal grant for called the Recovery Community Support Program (RCSP). This was an opportunity to blend my recovery with my activist spirit and do it in a way that felt really whole and healing. It was a really wonderful opportunity. That's how I ended up back at the Center working full-time and starting the RCSP program we called "Speak Out: LGBT Voices for Recovery."

**Bill White:** What do you think were some of the most important accomplishments of your work at Speak Out?

**Tom Hill:** I think first and foremost was confronting this multiple stigma. It wasn't just the stigma of addiction and even recovery; it was the stigma of being queer, of being lesbian, gay, bisexual, or transgendered. It was this double and often triple stigma because we had people of color, people of criminal justice experience, and people who were HIV+ as well. People were facing compounded stigma. We formulated the idea of coming out as queer citizens and coming out as people in recovery. That was a huge thing for people who were used to hiding so many facets of their lives. The whole idea of coming out across the board and being very open about who we were was a tremendous accomplishment. Also, from the very beginning, we were really dedicated to being inclusive, as we represented many facets of queer life, age groups, and addiction and recovery experiences. We didn't just limit it to drugs, so anybody who felt like they were in recovery from any kind of addiction was welcome to that group. So from the beginning, the inclusive aspect had a healing as well as an activist spirit.

**Bill White:** Has the visibility of recovery within LGBT communities increased since this early work?

**Tom Hill:** We've certainly come a long, long way, but recovery is a very complicated thing in the LGBT community. There's been a very strong 40-year history of visible LGBT 12-step meetings so in any major urban area, there's usually a very strong LGBT AA or NA presence. But the LGBT recovery

community is still very separate – and often a hidden reality – from the larger LGBT community. There is still a large bar and club culture in LGBT communities, and those folks usually don't spend a lot of time talking about recovery.

**Bill White:** There's such a deep tradition of political advocacy within LGBT communities. Are there lessons learned within that advocacy tradition that are relevant to the recovery advocacy movement?

**Tom Hill:** When the AIDS epidemic hit the gay community in the very early 1980s, it followed on the heels of a decade of strong political advocacy and community volunteerism in the 1970s. Those advocacy efforts had produced two critical pieces of infrastructure for the AIDS movement: the lesbian feminist health movement that focused on women-centered health care and STD clinics that served primarily gay men. So when the AIDS epidemic hit, this pre-existing infrastructure helped us to begin mobilizing resources to take care of our own. When the response to AIDS from the government and the larger community was pitifully inadequate and often hostile, there was an alternative medical and volunteer infrastructure that was able to mount a response to this public health epidemic. At the same time, activist groups formed to put pressure on the government and pharmaceutical companies to respond.

**Bill White:** It seems like there were broader organizing principles from the LGBT advocacy movement that you were able to integrate into your work at Speak Out – principles such as inclusiveness.

**Tom Hill:** When I was first involved with recovery advocacy, the movement was mostly older, middle-aged white guys in AA, and then it grew outward from that core. I had seen that happen in the LGBT community, originally called the gay community, then the lesbian and gay community, and then the lesbian, gay, bisexual, and transgender community as we kept broadening it to encompass people's experience and identities, to be inclusive. There were important lessons I took from this about the tension that comes from moving toward inclusiveness. How to work with and lift up the experiences of the most marginalized was often a point of discussion. How do you add experiences of people of color? How do you add the experiences of women? How do you do all that authentically while you're building a movement and do it through a consensus process? I've seen this same struggle in the 12-13 years of working with the recovery advocacy movement. The folks that show up now look very different than they did in 1998, which is really a great change.

**Bill White:** Speak Out was among the first CSAT RCSP grantees, and I'm wondering if you could describe what it was like when those early recovery advocates came together through the RCSP.

**Tom Hill:** You first have to understand how green we were starting out. When I first got the job, Barbara Warren told me on my first day, "Cathy Nugent wants to talk to you because you have to speak at the NADAAC conference." And I was like, okay, well, "Who's Cathy Nugent and what's NADAAC?" I was quite nervous about the whole thing. I called Cathy about 7 times and hung up every time. And then when I talked to her, she was just the nicest person in the world and said she wanted me to speak on this panel about community organizing at the NADAAC conference. I'd never been to treatment, I didn't have health insurance, and I didn't know anything about any of that stuff. I spoke on this panel with Bob Savage and William Cope Moyers, and I didn't know who they were. I just talked about coming out and visibility. I talked about the lessons I had learned as a member of the LGBT community and how they might apply to recovery advocacy, as well as how coming out had to be one of the first items on a community organizing agenda.

A few months later, we went down to DC for the RCSP meeting, and there were 19 grantees. I met people like Bev Haberle, Bob Savage, Phil Valentine, Don Coyhis, Joe Powell, and Donna Dmitrovich. I don't think many of us knew what we were doing at that point, but the atmosphere was just crackling with possibilities. I had been working in a vacuum for a number of months, trying to put something together and not really knowing how best to do it. I took comfort that everybody else was in the same boat, but then we started sharing information with one another. "Well, this didn't work here, what could I do?" "This is what worked for me." It was like going to meetings – the kind of sharing that happens from people who were trying to figure out how to stay sober. I had this feeling deep in my gut that this was the exact right thing to be doing and that this was really something that was going to gain traction. It was one of the most exciting periods of my life. These meetings were so important for me because I otherwise felt that I was leading in isolation. On really difficult days, I'd think: "Why am I doing this? I have no idea what I am doing." And I would pick up the phone and call one of the other RCSP leaders for encouragement or commiseration. And that helped me so much.

**Bill White:** A lot of us cite the 2001 Recovery Summit in St. Paul as the detonation point of the new recovery advocacy movement and the launch of Faces

and Voices of Recovery. How important do you think RCSP was in really setting the stage for the Summit?

**Tom Hill:** Before the Summit, one of the things that we talked about when we came together for RCSP grantee meetings was about a national movement. Many of us asked CSAT (Center for Substance Abuse Treatment) if we could have time and space at the end of one of our RCSP meetings to discuss this. At one point, we had a facilitator come in, and there was a lot of initial discussion about how a national movement could be launched. These discussions coincided with planning for the Summit in St. Paul. When we were all at the Summit, these discussions came to life. Jeff Blodgett and William Cope Moyers were key organizers of that meeting, but we all had representatives there. RCSP was pretty instrumental in shaping the Summit. Our focus at that point was more on recovery advocacy than recovery support. At the Summit, RAP (Recovery Association Project), an RCSP grantee from Portland, Oregon, did a whole track on community organizing using their experience with the Alinsky method of community organizing. That was very instrumental in shifting people's ideas at that summit toward this vision of recovery community mobilization.

### **An Evolving Movement**

**Bill White:** Shortly after the Summit, the RCSP program shifted from a focus on recovery advocacy towards peer recovery support services. What do you feel was the historical significance of that shift?

**Tom Hill:** Right before the Summit, June Gertig hired me to work on providing technical assistance to the RCSP grantees on recovery advocacy. I moved from New York to DC. Within 6 months at my new job, I was informed that the RCSP was changing from advocacy to peer services. I felt like the wind had been taken out of my sails and was not sure how this was all going to work out.

Originally, the RCSP was set up as a way to mobilize people in recovery to advocate for more treatment dollars. When we were starting up our grants, many of us found that people in recovery were not interested in that. Many talked about the lack of community supports – besides 12-step groups – that would help them get back on their feet in recovery. So, we started organizing around the lack of supports in the community that went beyond mutual aid that could help nurture recovery after treatment (or in place of it for some). So June Gertig and I looked at all different kinds of peer programs in HIV and mental health to see what peer recovery supports might look like in addiction recovery, and I got excited about some of the possibilities. We had to do a lot of research before we unfolded it to



the existing and to the second round of RCSP grantees that were awarded in 2001. First we had to inform them that they had to shift their programs from advocacy to peer services, which was not greeted warmly by many of the grantees. When that roar settled down, we offered them guidance on how they could start putting this new model in place. It was initially fraught with a lot of frustration and challenges before we began to fully discover the opportunities.

A key milestone was a mini-conference we put together in 2004. We did a series of them around the country in place of the annual conference in DC. We did one in El Paso with the Recovery Alliance as host – they were one of the recovery community centers. We also highlighted Diane Potvin from CCAR, who had just opened up their first recovery center. Barbara Warren talked about the LGBT community center, and she helped incubate the whole idea of what a recovery community center might look like and how such centers could be developed in local communities. Directly following that meeting, there was a tremendous energy all over the country to start up recovery community centers.

**Bill White:** One of the distinctive features of the recovery advocacy movement during these early years was the commitment to the value of inclusiveness. How well do you feel we've done since then as a movement in reaching that vision of inclusiveness?

**Tom Hill:** I would connect this back to what we were talking about earlier. A lot of those early discussions around peer services were about what we meant by peer and peerness, and those discussions began to resonate with people. First of all, nobody wanted to make a shift. They were all geared up to be advocates and then they were told that, in order to keep their money, they had to sort of shift to peer support services. But community service was always part of our vision, and we were challenged to translate this in new ways. As we did this, we faced the issue of how to maintain this value of peerness, authenticity of voice, and the lived experience of recovery in the service setting. And we reached early consensus that part of that peerness involved the need for diversity and inclusion.

We faced many questions: How do you do culturally specific peer services? How do you do things that invite a diverse array of experiences and cultures and lives into a program? I actually think we've done pretty well with this. Since 1998, we have become a much more culturally diversified movement. We still have a long way to go, and I think we need to consciously have this discussion all the time, but we have come a long way in learning the value of being accepting and inviting to all different kinds of recovery and cultural experiences.

Another area of growth has been the inclusion of people and communities of medication-assisted recovery. That is an ever-evolving dialogue, but I think there is

a greater understanding, especially around methadone, that it is not equal to drug use. There is still room for enlightenment in many minds, but change is beginning to take hold. One thing I always try to remember is to take my role as an ally seriously. There will always be marginalized members and groups in any community, and they deserve to be included and to have others stick up for them. If I am in a more privileged position, it is my responsibility to hold the door open for others and to help them up the rungs of the ladder.

## **On Servant Leadership**

**Bill White:** Tom, I think one of the many contributions you have made to the recovery advocacy movement is the work you have done promoting servant leadership principles. Could you highlight a few of those principles for our readers?

**Tom Hill:** There are two tracks of servant leadership. One is Greenleaf track about how such leadership happens in organizations and corporations. The other is a more spiritual and even Judeo-Christian track that talks about servant leadership in churches. Even though I don't identify as Christian, I attended a leadership school in Washington, DC at a Christian, very "churchy" institution. Their basis for servant leadership was that Jesus was the champion of the underdog, those who were neglected, scorned, and broken, and this brokenness allows us to open up in new ways and heal through helping others. Surrendering to brokenness can be the greatest act of strength. Sounds familiar, right? So, I've drawn from that the idea of the wounded healer that Henry Nouwen and Parker Palmer have written about. I just kept taking these ideas back to my recovery experience and applying them to the extension of service work within the recovery advocacy movement. We become transformed through our acts of service.

The central idea is that we heal ourselves by helping others to heal, and that is related so directly to the fact that we recover together. It's through my sense of brokenness in addiction and my journey to recovery that I'm able to fully show up and help others who are going through these same experiences. By doing that, by extending myself through service, I get healed in the process. It's a mutual exchange of healing and helping. That's one of the core principles of servant leadership, and it is a style of leadership that requires foresight, reflection, minimization of ego, and community-building. You need all these essential ingredients that really do elevate principles over personalities. This is a different kind of leadership that is normally practiced in our culture and requires a degree of self-reflection and honesty.

**Bill White:** This is the 10-year anniversary of the St. Paul Recovery Summit. I'd be very interested in your critique of the progress you've seen in this past 10 years.

**Tom Hill:** I'm so proud of what we've accomplished in 10 years, and I'm actually amazed by it all. We've done a lot of movement-building and institution-building, and all that takes time and resources. I can get a little bit impatient. I cut my teeth on AIDS activism at a time this was a life or death matter. We have accomplished a lot in the recovery advocacy movement, but I don't think we have that sense of urgency. I've had conversations with lots of people to figure out how we can really convey that addiction is something that kills and to bring that forward in a way that gives our movement a greater sense of urgency and gives communities a sense of what is at stake and the hope that comes with recovery.

You and I were in Philadelphia last September and witnessed more than 10,000 people turn out, and seeing all those people in recovery brought tears to our eyes. At the same time, many of the participants were still obviously in treatment, and I wondered why we were not seeing greater numbers of folks in long-term recovery. I remember thinking, "Where are the folks with 2 years, 5 years, 20 years, or 30 years?" We still haven't created a threshold of reaching a larger proportion of those people to come and join us. I think that remains a challenge for us. Many people in recovery still accept or minimize the stigma and invisibility that keeps recovery a societal secret. Getting large numbers of people in long-term recovery to "cross the line" remains a challenge. This will happen more and more, but maybe more slowly than we'd like.

**Bill White:** I've been thinking about another group as well – families who have lost a loved one to addiction. We have done much to celebrate recovery, but we haven't created a niche in the movement to genuinely mourn the people we've lost and to honor and invite the stories of families who've lost someone.

**Tom Hill:** Absolutely. They just become invisible and isolated. In the next phase of the movement, we must find a way to acknowledge those individuals and create roles for their family members. Again, lessons from the HIV/AIDS movement. Helping family members, colleagues, and communities to acknowledge and mourn the multitudes of vital lives lost to addiction.

**Bill White:** What other challenges and opportunities do you see facing the future of the recovery advocacy movement?

**Tom Hill:** Health reform is going to certainly provide some opportunities, but as you know, with every opportunity comes 12 challenges [laughing]. The coming



reforms will shift the role of treatment and recovery support services, and they will both be a greater part of the larger health care conversation because of parity. I think there are opportunities within the integration of mental health and primary care, but there are lots of challenges related to that as well. The questions will be: How do we hold our ground as distinct communities while acknowledging what we share with other healing communities? How do we maintain our autonomy and integrity while becoming more integrated into the larger health care system? Addiction recovery communities have a unique culture that I would hate to see get lost in attempts toward integration. Also, it is important that the concept of recovery does not become so generic that our folks cannot identify with it or see themselves in it.

In other areas, there seems to be a renewed vigor in demonizing folks with addiction. Lots of bad policy is currently on the books that targets poor people to be drug tested in order to receive public assistance. Things like this present issues for the organized recovery community to mobilize and advocate. Punishing poor people who may or may not be using substances is directly connected to all of us with addiction and recovery histories.

**Bill White:** One of the challenges that we have discussed in the past is the issue of leadership development within the recovery advocacy movement. What do we need to be doing to cultivate future leaders?

**Tom Hill:** I think a couple things. First, we need to recognize a youth recovery movement that is starting to get traction that will likely experience significant growth in the next few years. From the beginning, I've wondered, "Where are the young people in recovery? Why aren't we bringing up young leaders?" It's great to now see the emergence of such leaders and there are going to be great leadership opportunities in the coming years. The second thing is to develop the leaders we now have in place. We had an executive director leadership academy last month in Detroit that was an outgrowth of Faces and Voices of Recovery having helped create ARCO, the Association of Recovery Community Organizations. That was a wonderful opportunity to bring people together for leadership development. My hope would be to have this leadership academy evolve into a larger annual conference where people can come together to exchange ideas, enhance their skills, and offer each other support for this work.

An area that is always a concern, especially in recovery community leadership, is self-care. We don't always practice what we tell others. There is always going to be too much work that needs to be done and not enough folks to shoulder the work. After a day of heavy lifting, we need to have something in place to replenish the well. Another important lesson I have learned is that doing

recovery advocacy work has to be separate from my personal recovery work. I cannot rationalize that it's all recovery work, so it's okay if I skip a meeting or cut back on meditation time. We see leaders fall all the time in general society, and we need to safeguard against that, especially in our community.

### **On the Dangers of Professionalization and Commercialization**

**Bill White:** There are concerns in all social movements about the dangers of professionalization and commercialization. How do you see these forces at play in the recovery advocacy movement?

**Tom Hill:** Oh, that's a good one. As in the AIDS movement, we are providing needed services that no one else was providing and still trying to maintain our advocacy missions. I think that is a very delicate balance, and this balance can be compromised by these forces that you note.

One of the things that we are trying to hold ground on is keeping those services as peer-oriented as possible and not following the path toward paraprofessional or professional status as has happened in the mental health and other fields. No judgment on that, but we see lots of dangers in people going from a focus on personal and community experience to paraprofessional roles and then to inevitable efforts to professionalize these roles. We don't want to repeat that again, but at the same time, health reform will bring opportunities and pressures for peer navigators and that could take those peers out of the community context and into a more formal systems context. I have no answers to this dilemma, but my eyes are wide open and watchful of what will be unfolding. And I think we will have to find a way to develop community control – for lack of a better word – on what we do through these roles. That's part of why Faces and Voices of Recovery took the accreditation route for peer services. We wanted to make sure we retain the peerness within these roles while maintaining a level of quality and accountability in services. But the bottom line is that peer services will be effective only inasmuch as they are fully grounded in the recovery community.

### **Consultation Reflections**

**Bill White:** You have provided technical assistance to new grassroots recovery support projects around the country. Are there lessons or reflections you could share that you have drawn from these experiences?

**Tom Hill:** It's really interesting because within the RCSP, there was always a split between grantees that were facilitating organizations that had a peer recovery

project and others that were recovery community organizations. The RCOs were very grassroots – often mom and pop kitchen table start-ups with a lot of passion and a lot of recovery-based experience. Technical assistance for them involved affirming what people already knew and then giving new tools, templates, and instruction on how to increase their organizational effectiveness. There’s a tremendous joy in doing that, in going into a community and figuring out what people are doing and then sort of helping them elevate their work. They oftentimes don’t have the business practices and infrastructure to run a federal grant, and that can be challenging.

And then there is the work with facilitating organizations, service organizations that don’t necessarily start from a peer perspective. The challenge there is working with the folks in recovery to establish a recovery culture within a larger organization that’s not historically recovery-oriented. And there’s a tremendous joy in that work as well. When you can help administrative folks understand a new recovery paradigm, maybe one they have never thought of before, there is always that moment of excitement where the possibilities seem endless. Then there are the folks who don’t get it, don’t want to get it, and probably never will get it. Then you stumble on a volunteer who is a complete diamond in the rough, with such passion and a desire to learn. Those are the folks who are so much fun to work with because you can see the fire in their bellies as they sprout and grow as nascent leaders before your eyes. I have been blessed with countless opportunities like this.

I always come back to the foundational belief that community members already know how to do much of this recovery support work if they are given the right tools and assistance to channel those natural resources.

## **Trends in Recovery Support Services**

**Bill White:** What do you see as some of the more important trends in the design and delivery of peer services? What is the best organizational setting for such services: a grassroots RCO, a faith-based organization, an addiction treatment center?

**Tom Hill:** We’re asking that question a lot now because of our involvement in countless discussions about health care reform. There will likely be new settings in which peers will be working. When peers work out of a recovery community center on Main Street, recovery values and connections to the recovery community tend to remain intact. Peer services can work in a wide variety of settings, but it will be important to establish and maintain those same values and connections

when they are delivered in treatment centers, prisons and jails, AIDS organizations, or in community colleges.

Peers can work in any context and setting, but certain safeguards must be in place to assure that their work is respected and valued. I'm always concerned about how vulnerable the peer is in other settings where they don't have the community to support them. So how do you make such support portable in a way that peers can assert themselves safely in environments where they have little ownership? I think the design of peer services has to be considered very carefully in such settings. I think supervision is the key to all of this – supervision that is not just monitoring but support as well. There is a trend towards mandating clinical supervisors for peers. I'm afraid that this is a huge mistake, and we are countering this by asserting that a supervisor should be qualified and experienced to supervise peers. It is important to be conscious and sensitive to the difference in peer practice and settings.

**Bill White:** One of the challenges we're facing now is the tightening of the federal and state budgets. How are RCOs and other organizations responding to this increased competition for shrinking resources?

**Tom Hill:** I think these conditions can feed misconceptions about peer services and their misuse. It is likely in this climate that peer coaches will be used to replace case managers and care coordinators. In many cases, there is a tendency to cast peer roles as "treatment lite." There is not yet clear delineation between such roles. There is a tendency to look at peer practice as cheap labor and the exploitation of these roles is a danger in the current economic context. Peer services are cost-effective but not cheap, and efforts are needed to assure the peer experience is valued apart from issues of costs. I think we need to package that, communicate it better, and let other service providers know that we are available and willing to help in the correct context, but we refuse to be exploited and misrepresented.

### **Faces and Voices of Recovery**

**Bill White:** You've recently joined the staff of Faces and Voices of Recovery. Has your perception of recovery advocacy and peer recovery support shifted from this new position?

**Tom Hill:** Yes, I am going to be coming to Faces and Voices full-time the first of the year (2012). I've been with a federal contractor for 10 years, so everything I've done has involved working through the federal government. At this point of

my life and career, it will be nice to be freed up from the restrictions that come with such a role. Working for a recovery advocacy organization like Faces and Voices will give me a chance to reach a broader span of organizations and exert an influence on the recovery advocacy movement as a whole. I have been fortunate to have professional roles that have allowed me to grow individually and professionally, and to be of service to others in a number of capacities. I think this new chapter will expand those capacities ever further.

### **Service Reflections**

**Bill White:** In looking over your service activities of that past decade, what are some of your best moments working as a full-time recovery advocate?

**Tom Hill:** I have been so blessed to work with the best and brightest in the recovery community and in the entire addictions field. I've been invited to go places and be places I could not have dreamed would have been possible. I've been able to converse with leaders I was previously in awe of, people like you, Bill. To have access to that kind of leadership has been a tremendous opportunity for me. A lot of us didn't really think that this was what we were going to end up doing with our lives. Many, including myself, feel like we were called to this. "To whom much is given, much is required." The gifts we are given in recovery, that second chance to do things different and better, also can become an obligation to put something back in: servant leadership in action. There's been something very special that has kept me engaged: with communities, working with leaders, just the opportunity to be a part of something that I think really has been a radical and positive shift in society.

We talked about what's needed to go to the next level – we'll figure that out in time, I guess, but whoever thought that recovery would become a household word? You know, the solution of recovery is really starting to become visible in American society after decades of being a best kept secret. To be a part of that uncovering has just been a thrill I had not counted on in this lifetime.

**Bill White:** Tom, thank you for all you've done for the recovery advocacy movement and for your continued friendship over this past decade.

**Tom Hill:** Well, it's been an honor, it really has

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