The Status and Future of Addiction Recovery Support Services in the United States

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Abstract

Addiction recovery support services (RSS), including recovery housing, schools, coaches, ministries, and community centers, are rapidly spreading in the United States. In February 2012, the Betty Ford Institute and the University of California, Los Angeles, convened an expert consensus conference to address four questions related to the growing RSS phenomenon: (1) What is new in the delivery of RSS in the United States? (2) What is known about RSS from the standpoint of science, practice, and experience? (3) What does the addiction treatment and recovery field need to know about RSS? (4) What are the next steps needed to develop, refine, and evaluate RSS? This article summarizes the expert panel's findings and recommendations.

Keywords: peer support, recovery, mutual aid, recovery support services, consensus conference

Introduction

Recovery from addiction is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship (Betty Ford Institute Consensus Panel, 2007). Historically, specialized support for recovery from alcohol and other drug addictions in the United States has been provided by peer-led mutual-aid organizations and professionally led addiction treatment organizations. The former include Native American abstinence-based religious/cultural revitalization and healing movements, 19th century recovery societies (e.g., Washingtonians, recovery-focused fraternal temperance societies, ribbon reform clubs, Keeley Leagues), Alcoholics Anonymous (AA) and its 12-step offshoots (e.g., Narcotics Anonymous, Cocaine Anonymous), mutual help organizations that reject any AA-style spiritual content (e.g., SMART Recovery) and, conversely, others (e.g., Celebrate Recovery) that forgo AA's generic "higher power" concept to instead employ an explicitly religious approach (Kelly & White, 2012). The latter span early inebriate homes and asylums, private addiction cure institutes, bottled and boxed home cures, and the late 20th century evolution of today's addiction treatment system in which evidence-based practices play an increasing role (White, 1998).

In the past two decades, a type of addiction recovery support has emerged that does not fit perfectly in either the category of peer-led recovery organizations or professional addiction treatment. This service form encompasses new social settings (e.g., recovery community organizations, recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries) and service roles (variably called recovery coaches/guides/mentors, recovery support specialists, or peer support specialists; Cousins, Antonini & Rawson, 2012; White, 2008, 2009; White, Kelly, & Roth, 2012).

The development of such "recovery support services" (RSS) raises numerous questions, opportunities, and challenges for the field. Accordingly, in February of 2012, the Betty Ford Institute (BFI), in collaboration with the University of California, Los Angeles (UCLA), hosted a consensus conference to explore the history, status, and future of recovery support services in the United States. Discussions were organized around four broad questions:

1) What is new in the delivery of recovery support services (RSS) in the United States?
2) What is known about RSS from the standpoint of science, practice, and experience?
3) What does the addiction treatment/recovery field need to know about RSS?
4) What are the next steps needed to develop, refine, and evaluate RSS?

This article summarizes the conclusions drawn from the BFI/UCLA Consensus Conference and briefly discusses the potential historical significance of RSS.

Several important historical trends set the stage for the 2012 BFI/UCLA Consensus Conference. These include the growth and diversification of addiction recovery experiences across and within secular, spiritual, and religious addiction recovery mutual-aid groups in the United States during the second half of the 20th century (Humphreys, 2004; White & Kurtz, 2006), the perceived disconnection between addiction treatment and the larger and more enduring process of long-term addiction recovery (Elise, 1999; Morgan, 1994), the emergence of a new grassroots recovery advocacy movement in the United States (White, 2007b), and the rise and maturation of recovery community organizations (RCOs) organized by and on behalf of

people in recovery, whose missions include policy advocacy and the delivery of peer-based recovery support services (Valentine, 2011; White, 2009, 2010).

Also influencing the emergence of RSS are the reconceptualization of addiction as a chronic medical disorder (Dennis & Scott, 2007; Flaherty, 2006; McLellan, 2002; McLellan, Lewis, O'Brien, & Kleber, 2000), the clearer articulation of the stages of long-term personal and family recovery (Brown & Lewis, 1999; Dennis, Scott, Funk, & Foss, 2005), calls to extend addiction treatment from models of acute biopsychosocial stabilization to models of sustained recovery management (Flaherty, 2006; Humphreys & Tucker, 2002), efforts to nest recovery management approaches within larger recovery-oriented systems of care (ROSC; Kelly & White, 2011; White, 2007a, 2008), and the promotion of RSS within and entirely outside of the formal health care system (Achara-Abrahams, Evans, & King, 2011; Clark, 2008; Kaplan, 2008; Kirk, 2011; Valentine, 2011). A further recent contextual influence is the expectation that services for alcohol and other drug problems, including RSS, will be expanded and integrated into other community service institutions as an outcome of the Affordable Care Act of 2010 (Buck, 2011; Hill, McDaid, & Taylor, 2012).

Seen as a whole, these trends reflect an increasing momentum toward the adoption of a recovery paradigm as a central organizing construct for the addictions field and the integration of RSS as part of larger transformation efforts within recovery-focused systems of care in the United States and in the United Kingdom (Berridge, 2012; El-Guebaly, 2012; White, 2005, 2008). These trends also suggest the need for a recovery research agenda to guide this re-orientation of the field's conceptual foundation and service practices (Laudet, Flaherty, & Langer, 2009; Laudet & Humphreys, 2012).

The Consensus Process

The Betty Ford Institute (BFI)—the prevention, education, and research arm of the Betty Ford Center—has for the past 7 years hosted a series of consensus conferences aimed toward the goals of defining recovery (Betty Institute Consensus Panel, 2007, McLellan, 2010), extending the benefits of addiction treatment through innovative continuing care strategies, (McKay et al., 2009), enhancing graduate medical school education in addiction (O'Connor, Nyquist, & McLellan, 2011), and breaking the intergenerational cycle of addiction through parent-focused strategies.

A total of 30 individuals participated in the RSS Consensus Conference convened in February 2012 at the Betty Ford Center in Rancho Mirage, California. The purpose of the conference was to discuss the status and future of RSS within the addictions field. Those present included a moderator, four speakers, three policy experts, seven community content experts (including representatives from recovery community organizations), three addiction research experts, and 15 observers. The policy experts included representatives from the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Office of National Drug Control Policy.

The consensus process involved the presentation of papers on the history of RSS (White, 2012), the current RSS landscape (Hill et al., 2012), and research to date on RSS (Laudet & Humphreys, 2012); a facilitated discussion of the four guiding questions outlined above; and identification of points of group consensus and recommendations. To avoid premature

consensus, the facilitator and participants put special emphasis on drawing out disagreements and difficult issues.

Following the conference, participants were asked to complete an online survey rating their top RSS priorities drawn from the recommendations generated at the conference. Results were tabulated and are presented in the present article.

Results

There was clear consensus on the most significant aspects of RSS as they are developing in the United States. First, RSS rest on the premise that efforts to facilitate recovery from addiction should be grounded in an understanding of the chronicity and complexity of such disorders. A given RSS might be delivered in tandem with treatment, mutual aid organizations, or both of these entities, or it might be delivered independently. As a class of intervention, however, RSS are organized to offer longer-term support than that provided by acute care addiction treatment as well as a broader range of support than that provided by either recovery mutual-aid organizations or addiction treatment programs.

Second, RSS are distinctive in their frequent delivery within new recovery-focused entities (recovery community organizations, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes) and within such varied community settings as jails, schools, and Federally Qualified Health Centers. Rather than exclusively ask, "How do we get the person in need to a treatment center or mutual aid meeting?" RSS providers ask, "How do we deliver nested recovery support within the settings where he or she is already involved?" As this conceptualization suggests, the formal treatment system is only one of many venues through which RSS are provided.

Third, those providing RSS extol the legitimacy of multiple long-term pathways of recovery and value personal choice in the recovery process. This distinguishes them from mutual help organizations that facilitate travel down a single pathway to recovery (i.e., the pathway of that particular fellowship). RSS include assertive linkage to a broad spectrum of recovery mutual aid and treatment options, provide a larger menu of recovery support options, and utilize recovery-focused service planning protocols quite different from traditional treatment planning schema (Borkman, 1997).

Fourth, involvement of persons in recovery is common in the development and delivery of RSS (White, 2009). At the same time, individuals who have not personally experienced addiction are also often involved in RSS.

Fifth, RSS are distinctive in offering support across the stages of recovery—spanning pre-recovery engagement and recovery priming, recovery initiation and stabilization, recovery maintenance, enhanced quality of personal and family life in long-term recovery, and support in breaking intergenerational cycles of problem transmission. Also of note is that RSS can be provided before, after, or in tandem with professional treatment, or in lieu of such treatment. Prior or concurrent treatment is rarely a requirement for participation in RSS.

Other distinguishing aspects of RSS noted in the consensus panel discussions include the more assertive style of RSS (compared to most recovery mutual aid or professional treatment initiatives), the greater emphasis on advocacy as a critical dimension of RSS, the extensive use of volunteers—particularly peers—in the delivery of RSS, the differences in ethical guidelines

for RSS compared to those for addiction counselors, and a focus on the community as an object of change as well as the individual and family (White, 2012).

In reviewing existing RSS trends and RSS-related research, the consensus panel drew five major conclusions.

1) RSS have been implemented in a wide variety of organizational and community settings (Hill et al., 2012). Further, RSS have been tailored to the needs of special populations (including support for those in medication-assisted recovery from opioid addiction), adapted across diverse cultural and linguistic contexts, and often provided in gender-based settings.

2) Experience confirms that there is demand for RSS. Individuals and families in all stages of recovery are seeking and using such services in tandem with, and in lieu of, professional treatment and mutual help organizations.

3) Recovery community organizations (RCOs) and other organizations are identifying critical aspects of the implementation of RSS, e.g., methods of recruiting, screening, training, and supervising RSS providers.

4) The proliferation of RSS in the United States and the United Kingdom is far ahead of the research directly evaluating the short- and long-term effects of such services (Laudet & Humphreys, 2012.) Nevertheless, the theoretical rationale for RSS is buttressed by research showing the positive influence of social support on short- and long-term recovery outcomes (Beattie & Longabaugh, 1999; Groh, Jason, Davis, Olson, & Ferrari, 2007; Humphreys, Mankowski, Moos, & Finney, 1999; Humphreys, Moos, & Cohen, 1997; Stout, Kelly, Magill & Pagano, 2012), comparisons of social versus medical model programs (Kaskutas, Witbrodt, & French, 2004; Kaskutas, Zavala, Parthasarathy, & Witbrodt, 2008), and studies evaluating assertive approaches to recovery checkups and continuing care for adults (Dennis & Scott, 2012; McKay, 2005, 2009; Scott & Dennis, 2009; Scott, Dennis, & Foss, 2005) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2007).

5) Research in some RSS arenas is quite strong (e.g., recovery housing; Jason & Ferrari, 2010; Jason et al., 2007; Polcin, Korcha, Bond, & Galloway, 2010). For others, the research base is descriptive (e.g., recovery schools and collegiate recovery communities; Cleveland, Harris, Baker, Herbert, & Dean, 2007; Harris, Baker, Kimball, & Shumway, 2008; Moberg & Finch, 2008) or non-existent (e.g., recovery community centers, recovery-focused work programs, recovery ministries, and recovery cafés). Especially troubling is the paucity of research on RSS specialty roles (e.g., recovery coaches), given their rapid proliferation across the United States as a component of efforts to embrace models of recovery management and recovery-oriented systems of care. More positively, administrative data gathered on high-profile national initiatives, such as the Substance Abuse and Mental Health Services Administration's Recovery Community Services Program and Access to Recovery, suggest positive effects of RSS on recovery outcomes (e.g., sobriety/remission, improvements in global health, community reintegration; Laudet & Humphreys, 2012; White, 2009).

Consensus conference discussions of an RSS research agenda focused, in order of perceived priority, on the need to (1) assess the effectiveness and cost-effectiveness of particular types of RSS in producing outcomes in individuals and families, within treatment systems,

within local communities of recovery, and within communities more broadly; (2) gather and synthesize practice-based evidence and wisdom related to the optimal design and delivery of RSS; (3) conduct surveys that quantify the magnitude and methods being used to deliver RSS in the United States; (4) identify active ingredients of RSS and particular service combinations and sequences that most strongly influence recovery outcomes; and (5) create and validate instruments to assess individual and family needs for particular types of RSS. Some of the more specific questions posed within this discussion are presented in Table 1.

Table 1: What we need to know about Recovery Support Services (RSS)

Assessing the effectiveness and cost-effectiveness of RSS	What are key elements of recovery that would lend themselves to measurement as RSS outcomes (e.g., sense of self-efficacy, quality of life, recovery/social capital, etc.)? Are there differences in outcomes influenced by the recovery status of the person delivering RSS or by the organizational setting through which RSS are delivered? Does the duration and amount of contact influence the effectiveness of RSS? Do RSS avert or reduce use of costly acute care services (e.g., emergency rooms)? What existing measures might be adopted to measure some or all identified elements?
Optimal design for RSS	What is a typical menu of RSS? How do RSS coming out of RCOs and treatment organizations differ from each other, if at all, and from those being offered by the life coaching field? What are the key quality indicators of RSS? What qualifications are required to deliver RSS? How does personal or family recovery by providers affect delivery of RSS? Does the impact of RSS vary depending on whether staff are volunteers, paid, or a combination of such, or in recovery, not in recovery, or a combination? How are RSS being refined across boundaries of age, gender, culture, drug choice, and pathways of recovery?

	Is there an optimal length or intensity of service that RSS should provide? How many people can a single RSS provider serve simultaneously in different contexts and with different populations? How can people providing RSS be best supervised? How can RSS avoid becoming either a cheap form of treatment and a rationale for cutting treatment services, or, becoming commercialized to the point that they lose their grassroots nature and commitment to advocacy that make them appealing to those who access them ? What are the critical considerations in developing new RSS and new RSS service locations?
National, state, and local assessment of currently available RSS	What is the present national, state, and local availability of RSS? What is the current need/demand for particular types of RSS? What is the RSS needs profile of people at different stages of recovery? How is technology being utilized in the delivery of RSS?
Active ingredients/combinations of RSS	What are the most potent ingredients of RSS in terms of their influence on recovery outcomes? Which individuals are most likely to benefit from RSS? Are there particularly potent RSS combinations or sequences? Do these combinations or sequences need to be implemented during certain "critical" recovery phases to be effective? Are there ingredients unique to RSS that are not found in recovery mutual aid or professional addiction treatment?
Assessing individual and family need for RSS	Who is most likely to need and utilize RSS? How are organizations delivering RSS evaluating the support needs and service response of those they serve, e.g., individual and community needs assessments, tools, checklists, recovery planning formats? Is there a needs-and-strengths profile of people at different stages of

	recovery? If not, could it be developed?

The closing discussion of the RSS Consensus Conference generated an action agenda for RSS service providers, policymakers and administrators, and the research community. Table 2 displays the specific recommendations within these three arenas.

Table 2: Recommended and Prioritized Next Steps in the Evolution of RSS

For the RSS practice community	Clarify role boundaries between RSS provider, addiction counselor, life coach, and other service roles (e.g., case managers, outreach workers) and the relationship between RSS, recovery mutual aid organizations, and professional addiction treatment.
	Communicate to multiple stakeholders the precise purpose of RSS and their role in the larger service/support system and in the broader community.
	Survey RCOs, treatment providers, Access to Recovery sites, and Single State Agencies to establish a benchmark of current RSS practices.
	Create a central repository of documents, tools, media, etc., that can be used to enhance replication of RSS.
	Disseminate documents that can help educate policymakers, funders, treatment and allied service professionals, and the recovery community about the nature of RSS and evaluation results.
Policymakers and administrators	Integrate RSS within the implementation of the Affordable Care Act.
	Integrate questions related to RSS in national surveys of recovery prevalence and addiction treatment.
	Provide technical assistance and support to enhance the mobilization of local recovery communities and development of local recovering community organization RSS capabilities.
	Host and participate in conferences that include an overview of federal RSS initiatives, local RCO activities related to RSS, and what private managed behavioral health companies and disease management programs are doing with RSS.
	Evaluate states' Medicaid experiences with RSS and disseminate the

	findings
Researchers	Pursue quantitative and qualitative outcome studies of RSS.
	Develop a valid and reliable measure of recovery
	Use existing data sets to assess the potential need/market for RSS.
	Design new research in light of findings of prior studies (e.g. Kaskutas et al., 2004).
	Develop standard evaluation protocols for use by organizations delivering RSS.
	Create opportunities for dialogue between addiction researchers and representatives from recovery community organizations involved in RSS delivery.
	Examine comparable RSS for other health conditions for their effectiveness and transferability to addiction RSS

Discussion

The BFI/UCLA Consensus Conference review of current research and prevailing practices related to recovery support services drew five broad conclusions.

1. RSS are being implemented in diverse geographical, cultural, and organizational settings for people seeking recovery from addiction, those newly in recovery, and those in long-term recovery. Some people access RSS in combination with addiction treatment programs and mutual help organizations, whereas others do so entirely independent of these services.
2. Payers, providers, and the recovery community are showing increasing interest in RSS as a way to support recovery from addiction.
3. Although the development of RSS has strong theoretical support, rigorous research has been limited to particular recovery support institutions (e.g., recovery residences) and to particular recovery support protocols (e.g., posttreatment recovery management checkups).
4. The expansion of existing RSS, replication of RSS in new settings, and development of new RSS need to be informed by studies evaluating the effects of a wide variety of RSS components on short- and long-term recovery outcomes for individuals and families, and studies that contribute to the development of RSS practice guidelines and standards. At the same time, the practice of RSS cannot wait to proceed until traditional academic research projects are completed. Researchers and providers should gather, synthesize, and attend to practice-based evidence, rather than assuming that traditional research approaches can be the only guide to action.

5. The further development, evaluation, and refinement of RSS in the United States will require concerted action by the RSS practice community, policymakers, systems administrators, and the research community.

There are a number of important ways in which RSS models being replicated in U.S. communities could expand support for individuals recovering from addiction. RSS providers, such as recovery mutual-aid groups, frequently draw on the rich experiential knowledge and expertise of individuals in recovery (Borkman, 1976; Jackson, 2001). RSS could provide a menu of support services to a broad spectrum of individuals (including those without past or current treatment involvement) for an extended period of time (including pre-recovery engagement and long-term personal or family recovery). RSS can expand access to services and supports because they are delivered primarily within the natural environments of those receiving them (homes, neighborhoods, schools, churches, hospitals, jails). Another distinctive feature about RSS is that they strive for change not just in individuals but in the community. Specifically, RSS attempt to develop community recovery capital—the physical, psychological, and social space within the community where recovery can flourish (Granfield & Cloud, 1999; Humphreys et al., 1997). This focus on community goes well beyond the traditional clinical perspective of changing individuals (or, at most, individuals and their immediate family) and reflects the advocacy component of RSS.

RSS serve individuals who are on diverse pathways of recovery, including persons who initiate and sustain recovery without involvement in a mutual aid group. The RSS provider must therefore become knowledgeable and fluent across multiple pathways and styles of recovery initiation and maintenance, including working with persons with lower problem severity/complexity. RSS also address issues beyond initiation and maintenance of recovery, e.g., housing, education, employment, debt management, criminal record expungement, physical and mental health, exercise and nutrition, social networking, community service, advocacy opportunities, and recovery-linked involvement in art, literature, music, theatre, or sports.

RSS represent a new menu of recovery support mechanisms delivered in natural community environments through novel social institutions (e.g., recovery community organizations [RCOs]) and innovative service roles (e.g., recovery coach). The RCO is distinct from treatment organizations and recovery mutual-aid groups, and the recovery coach fits neither the categories of addiction counselor nor recovery mutual-aid sponsor/mentor. The critical question regarding the ideal means of resolving alcohol and other drug problems is not, "Should people seeking recovery choose professional treatment or a recovery mutual-aid group or RSS?" It is rather, "Are there ways that professional treatment, recovery mutual-aid societies, and RSS can be created and organized such that more numerous and more diverse long-term recovery pathways are available to more people?" Natural community experiments and controlled trials are needed to discover, for the treatment of addiction, what combined, sequenced, and stand-alone interventions have discovered for the treatment of AIDS and cancer. The advent of RSS creates an historic opportunity for such discoveries, though considerable challenges lie ahead in more clearly defining and more rigorously evaluating this expanding menu of services delivered through new roles and in new service settings.

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