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Situational Analysis

Recovery To Practice (RTP)

NAADAC, the Association for Addiction Professionals

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Table of Contents

Acknowledgments.....	2
Executive Summary	6
Introduction.....	7
Overview of the Project.....	7
NAADAC, the Association for Addiction Professionals	9
NAADAC RTP Team	10
Definitions and Components of Recovery	12
Guiding Principles of Recovery	12
Other Definitions of Recovery.....	13
Recovery-Oriented System of Care (ROSC).....	15
Snapshot of the Addiction Profession.....	16
Description of the Addiction Profession	16
History of the Addiction Profession and Recovery	18
Assessment Methodology	24
Qualitative Strategies	24
Quantitative Strategies	27
Contextual Conditions for the Addiction Profession.....	28
Economic Strengths	28
Economic Barriers	33
Political Strengths.....	36
Political Challenges	38
Social Strengths	40
Social Barriers	41
Technological Strengths.....	44
Technological Barriers	45
Recovery and the Addiction Profession.....	46
Definition and Understanding of Recovery	46
Response of the Profession.....	49
Use of Recovery Concepts, Skills, Knowledge and Practices	50
Education and Training	54
Professional Publications	62
Certification and Licensure	64

Organizational Functions.....	66
Implementation within States.....	68
Specific Areas of Focus	71
Culturally Competent Practice	71
Role of Trauma and Trauma-Informed Care.....	73
Co-occurring Disorders.....	74
Participation of Consumers and Family Members in Addiction Education and Practice.....	75
Peer Recovery Support Specialist (PRSS)	76
Medication-Assisted Recovery	77
Opportunities and Challenges: Curriculum Development and Training.....	79
Target Audience	79
Opportunities and Challenges	80
Appendix A: NAADAC Leadership	83
Appendix B: Addiction-Related Publications	84
Appendix C: Co-occurring Disorders Competencies.....	86
Appendix D: Co-occurring Disorders Scope of Practice.....	91
Bibliography	92

Executive Summary

Recovery has always had a stronghold in the addiction profession and its workforce. The addiction profession, founded by individuals in recovery, laid the groundwork to provide addiction services within a recovery orientation. Through the Recovery to Practice (RTP) Initiative, NAADAC was asked to determine the extent to which recovery-oriented concepts, values, and practices exist within all aspects of the addiction profession in order to develop a recovery-oriented training curriculum for the workforce.

Using SAMHSA's definition and guiding principles of recovery, NAADAC determined that recovery-oriented concepts, values, and practices are widely accepted and practiced within the addiction profession, but there is room for improvement in many areas.

In general, members of the addiction profession understand recovery-oriented concepts, utilize recovery-oriented practices, and have recovery-related opportunities for education, training, literature, certification, and licensure. There are some gaps in these areas, and many states are still in the early implementation stages of formally shifting to a recovery orientation. The response of the addiction profession to recovery concepts is generally enthusiastic whilst being met with apprehension from the workforce.

Many economic and political challenges to integrating a full recovery orientation within the addiction profession were discovered (funding and policy issues). In addition, social challenges (e.g. workforce resistance to change) and technological barriers (e.g. lack of full electronic records) also impede the adoption of a recovery orientation. However, there has been progress towards a recovery orientation, and there are many economic, political, social, and technological advances on which the movement can rely as it progresses. These challenges, barriers, and strengths are discussed in greater detail in the appropriate sections of this analysis.

As development of a recovery-oriented training curriculum for the addiction profession proceeds, special attention will need to be paid to improving the understanding and competency of trauma-informed care, cultural diversity, medication-assisted treatment, co-occurring disorders, and the role of peer recovery support specialists (PRSS). There are many challenges and opportunities present to developing a training curriculum for the addiction profession. It is essential to be solution-focused, instead of problem-focused, and encourage progression of the recovery movement within the addiction profession with a strengths-based approach. This means relying on the strengths for implementation and working to remove barriers and challenges where possible. Using this approach, it is possible and necessary to fully implement a recovery-oriented model of care.

Introduction

Since its inception, the addiction profession has been a leader in the recovery movement. The foundational principles of recovery originated from Alcoholics Anonymous (AA) and the Minnesota Model. Developed in the late 1940s, the Minnesota Model is an abstinence-based, comprehensive, and multi-disciplinary approach to the treatment of substance use disorders that is based on the principles of AA. This model maintains that substance use disorders are diseases with no “cure,” but with the real belief that recovery is possible. This model resonated with alcohol and drug abuse counselors, as most at this time followed the 12-Steps of AA, were in recovery themselves, and understood the progressive nature of recovery. Throughout the next several decades, the Minnesota model became the standard for all other addiction treatment programs and the term “recovery” was coined.

Recovery concepts have always run through the fabric of the addiction profession, the members of its workforce, and the services they provide, albeit with varying strength over time. The addiction profession has a rich history to build upon, and its professionals are poised to continue this movement. The inclusion of the addiction community in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Recovery to Practice (RTP) Initiative represents an opportunity to take us back to our “roots” of individual, family, and community recovery and transformation and reaffirm our commitment to this movement.

In this Situational Analysis, NAADAC describes a snapshot of how the addiction profession currently views and uses the concepts, services, and practices of recovery, as well as the barriers, strengths, and contextual conditions related to full integration. NAADAC will build on the opportunities and challenges discovered in this process to create a recovery-oriented training curriculum to better serve the addiction profession.

Overview of the Project

As a part of the federal government’s efforts to promote recovery for all Americans affected by mental illness and/or addiction, in May 2009, SAMHSA announced its Recovery to Practice (RTP) Initiative. The RTP Initiative is designed to hasten awareness, acceptance, and adoption of recovery-based practices in the delivery of addiction-related services and builds on SAMHSA’s definition and fundamental components of recovery (SAMHSA, 2010). The overall Initiative involves:

- (1) Creating a Recovery Resource Center, complete with web-based and print materials, training, and technical assistance for mental health and addiction professionals, and
- (2) Developing and disseminating curricula and training materials on recovery-oriented practice for each of the major mental health and addiction professions.

To guide this effort, SAMHSA desired to learn more about the depth and breadth of integration of recovery and recovery-oriented concepts within the various professions essential to the recovery movement and funded the Recovery to Practice (RTP) Initiative.

“By bringing together the major mental health and addiction professions with people in recovery, advocates, and other stakeholders (including experts in curriculum and workforce development), the RTP Initiative begins to address how we can translate the vision, values, and principles of recovery into the concrete and everyday practice of mental health and addiction practitioners” (Recovery to Practice E-News, 2010).

Six professional associations received awards through this Initiative:

- NAADAC, the Association for Addiction Professionals
- American Psychiatric Association
- American Psychiatric Nurses Association
- American Psychological Association
- Council on Social Work Education
- National Association of Peer Specialists

Through the RTP Initiative, NAADAC is tasked with the following:

- Assess the current status and needs of recovery-oriented principles and practices within the addiction profession;
- Design and deliver a national Situational Analysis with information derived from addiction professionals and review of the literature; and
- Develop an outline for a recovery-based training curriculum for addiction professionals.

The resultant curriculum outline will be utilized by NAADAC to develop a curriculum that will become a part of the national certification process for the workforce and will:

- (1) Educate addiction professionals about a recovery-oriented model of care;
- (2) Educate addiction professionals about addiction recovery (and their specific role in promoting it); and
- (3) Teach competencies needed to integrate addiction recovery concepts into practice.

NAADAC, the Association for Addiction Professionals

NAADAC, the Association for Addiction Professionals, represents the professional interests of more than 76,000 (Bureau of Labor Statistics, 2011) addiction counselors, educators, and other addiction-focused health care professionals in the United States, Canada, and abroad.

NAADAC's members are addiction counselors, educators, and other addiction-focused health care professionals, who specialize in addiction prevention, intervention, treatment, recovery support, and education. As an important part of the healthcare continuum, NAADAC members and its 46 state affiliates work to create healthier individuals, families, and communities through prevention, intervention, quality treatment, and continuing recovery support.

The addiction profession and NAADAC have grown hand-in-hand since the 1970s, by raising the profile of addiction issues and being a "thought leader" for the profession. NAADAC's role is similar within the recovery movement: to advance recovery concepts and lead the way to best practices.

By way of example, NAADAC's name changes over its existence demonstrate the continuous push for recognition of professionals and services beyond the profession's original roots and NAADAC's willingness to evolve as the profession does. Founded in 1974 as the National Association of Alcoholism Counselors and Trainers (NAACT), the organization's primary objective was to develop a field of professional alcoholism counselors with professional qualifications, competencies, skills, and attitudes. The organization evolved and became the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) in 1982, uniting professionals who worked for positive outcomes in alcohol and drug services. This change reflects the inclusion of drug abuse counselors as members of the addiction profession.

NAADAC's current name, adopted in 2001, - NAADAC, the Association for Addiction Professionals - reflects the increasing variety of addiction services professionals: counselors, administrators, social workers, and others, who are active in addiction specific counseling, prevention, intervention, treatment, education, and research. By embracing the term "addiction," NAADAC recognizes professionals who specialize in addiction related to substance use, as well as "process" addictions related to gambling, eating, sex, Internet/electronics, or shopping.

NAADAC's inclusion in the Recovery to Practice Initiative is natural, as recovery is organic to the work on which addiction counselors and administrators have historically concentrated their efforts. Further, the Recovery to Practice Initiative is core to NAADAC's mission and fits within the framework of its training, public awareness and public policy/advocacy efforts.

"NAADAC's Mission is to lead, unify, and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, standards of practice, ethics, professional development and research." - NAADAC Mission Statement adopted 1998

NAADAC is an organization designed to promote excellence in care by advocating for the highest quality and most up-to-date, science-based services for clients, families, and communities. NAADAC does this by providing education, clinical training, and skill building to the addiction workforce that supports recovery among those afflicted with addiction. Thousands of addiction professionals are trained through NAADAC's face-to-face seminars, online courses, webinars, home study courses, and conferences each year.

Through government relations, advocacy, and membership, NAADAC remains on the cutting edge of the addiction profession and recovery movement. NAADAC's leaders and members are making a difference in the current discussion and perception of addiction and recovery-related issues. NAADAC is a powerful advocate for policies improving the understanding of and financial support for prevention, intervention, treatment, and recovery support services of addiction.

Science has shown that addiction is a brain disease that responds well to treatment and recovery support services through a bio-psycho-social-spiritual paradigm. Research is continuously providing a better understanding of how addiction affects the brain. To this end, NAADAC supports continued research and development through its NAADAC Education and Research Foundation (NERF). The NERF has also produced numerous educational products related to recovery, such as conflict resolution and medication-assisted treatment and recovery.

NAADAC has demonstrated experience establishing standards and best practices for the addiction profession. In the late 1980s, it became apparent that a national credentialing system was necessary in order to provide a unified voice for the addiction profession and the work that was performed. NAADAC's credentialing body, The National Certification Commission for Addiction Professionals (NCC AP), developed national credentials that meet the same minimum standards across the nation for Levels I and II and Master Addiction Counselors. The NCC AP has credentialed more than 15,000 addiction counselors, playing an important role in sustaining quality health services and protecting the well-being of the public.

Finally, being the premiere membership organization for the addiction profession, NAADAC has direct access to the thousands of professionals in need of education, training, skills, and guidance on recovery-oriented concepts. Many of these professionals are actively engaged in the use of best practice models of treatment and are often times called upon to assist in the advanced development of training experiences within the scope of the mission of NAADAC. The use of this skill base serves as a means of continuing to reach those within the membership, both at the entry level as well as the more advanced practitioner, as a means of furthering their skill sets for treatment.

NAADAC RTP Team

To lead this Initiative, NAADAC has recruited the expertise of key addiction professionals and stakeholders. The composition of the NAADAC RTP Advisory Board includes consumers,

peers, family members, persons in recovery from trauma, clinicians, educators, and researchers, as well as persons who are directly engaged in recovery to practice initiatives at their local or national level. NAADAC's strategy follows the twelve-step tradition in that we are sharing our "strength, hope and experience" (Alcoholics Anonymous, 2003) in order to benefit the addiction professional through this Situational Analysis.

The NAADAC RTP Staff is composed of three clinicians with varying levels of experience within the addiction profession; as well as a specialist in strategic planning, media, and marketing; and a specialist on NAADAC membership. Combined, this team brings over 116 years of experience within the addiction profession to this project.

This project was largely driven and informed by consumers and peers, and their involvement was integral at each stage of development. Beyond the direct influence of the team members referenced above, NAADAC elicited comments from consumers and peers via email blasts, website announcements, blog posts, and direct requests to treatment providers to gather feedback from clients. This feedback was not only encouraged, but was viewed as essential to accurately reflect the current status of the addiction profession and the services it provides.

Definitions and Components of Recovery

To effectively assess the extent to which recovery-oriented practice exists within the addiction profession, it is essential to start from a unified definition of recovery. White (2007) suggests that an effective recovery definition must meet the criteria of precision (measurability), inclusiveness (embracing diverse pathways and styles of recovery), exclusiveness (what recovery is not and the circumstances under which this status is changed), acceptability (to multiple stakeholders), and simplicity (clarity and brevity). For the purposes of this Situational Analysis, SAMHSA's definition of recovery (2011) was used throughout:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Further, SAMHSA determined that there are four major dimensions that support a life in recovery:

- **Health:** *overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;*
- **Home:** *a stable and safe place to live;*
- **Purpose:** *meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and*
- **Community:** *relationships and social networks that provide support, friendship, love, and hope.*

Guiding Principles of Recovery

Beyond the definitions above, SAMHSA outlined ten guiding principles of recovery (2011):

- **Recovery emerges from hope:** *The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.*
- **Recovery is person-driven:** *Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).*
- **Recovery occurs via many pathways:** *Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds, including trauma experiences that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.*

- **Recovery is holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.
- **Recovery is supported by peers and allies:** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
- **Recovery is supported through relationship and social networks:** An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
- **Recovery is culturally based and influenced:** Culture and cultural background in all of its diverse representations, including values, traditions, and beliefs, are keys in determining a person’s journey and unique pathway to recovery.
- **Recovery is supported by addressing trauma:** Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.
- **Recovery involves individual, family and community strengths, and responsibility:** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
- **Recovery is based on respect:** Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

Other Definitions of Recovery

Many individuals and organizations have attempted to capture the definition of recovery:

Definition

Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one’s community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members. - (Philadelphia Department of Behavioral Health and Intellectual Disability Services, 2010)

Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship. (Betty Ford Institute Consensus Panel, 2007)

A patient is in a "state of recovery" when he or she has reached a state of physical and psychological health such that his/her abstinence from dependency-producing drugs is complete and comfortable. In practice, this judgment must be made on clinical grounds, based on the

most complete assessment possible of the state and seriousness of the initial illness and the quality and length of remission. An alcoholic individual is in remission when he/she is free of the active signs and symptoms of alcoholism. This includes abstinence from the use of substitute sedative, stimulant, or hallucinogenic drugs during a period of independent living. After a period of remission, which may vary for the individual, a state of recovery is achieved.

(American Society of Addiction Medicine, 2005)

“I’m (your name) and I am in long-term recovery, which means that I have not used alcohol or other drugs for more than (insert the number of years that you are in recovery) years.” **(Faces and Voices of Recovery, 2012)**

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. **(White W. , 2007)**

Recovering from alcohol and drug use disorders is a highly individualized experience, and everyone who goes through the experience has an individual definition of recovery. **(Recovery Services Community Programs, 2011)**

You are in recovery if you say you are. **(Valentine P. , 2011)**

Wellbriety is not a word but a concept that goes beyond the ideas of sobriety and wellness to define what is best for the whole naturally balanced person each of us seeks to become in life. Walking the Red Road to Wellbriety celebrates successful and continued recovery from alcohol and drug addiction and breaking the cycle of generational illness, rejoicing with Native families and embracing American Indian and Alaskan Native culture to create a future of promise. **(Red Road to Wellbriety, 2012)**

Further, international interest in recovery as an organizing paradigm for policy, clinical practice, and long-term community-based recovery support has spawned innumerable efforts to define recovery around the globe:

- *Australia: Recovery is a voluntary self-determined process toward minimisation or cessation of drug-related harms. This involves fostering healthy supported connections, such as with self, family, peers, and community, and is premised upon fair access to pre-requisites for wellbeing (Anex, 2012).*
- *United Kingdom: Recovery is voluntarily sustained control over substance use, which maximises health and well-being and participation in the rights, roles, and responsibilities of society (UK Drug Policy Commission, 2008).*

Even though these definitions vary in language used, they share common themes and contain many of the elements within SAMHSA’s definition of recovery and guiding principles of recovery: being a process, emerging from hope, person-driven, via many pathways, and supported by the community and others.

However, SAMHSA’s definition and guiding principles of recovery departed from the other definitions by including language related to being holistic, culturally based and influenced, addressing trauma, and being based on respect.

SAMHSA’s definition of recovery and ten guiding principles were the focal point for observation and discussion throughout this Situational Analysis and will form the foundation for any resulting curriculum through this Initiative.

Recovery-Oriented System of Care (ROSC)

Although recovery-oriented systems of care (ROSC) are not the primary focus of this Situational Analysis, it is important to understand the movement in which recovery-oriented practices are projected to exist. According to SAMHSA (2011), recovery-oriented systems of care (ROSC):

Provide a network of services and supports to address the full spectrum of substance use problems, from harmful use to chronic conditions. Through education, communities are strengthened by recovery-oriented activities that can prevent inappropriate substance use before it occurs. Education also raises awareness about the disease, dispels myths that foster stigma and discrimination, and provides early intervention for those at risk of developing substance use conditions.

William White summarized ROSC best by stating the following:

“The phrase recovery-oriented systems of care refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The “system” in this phrase is not a federal, state or local agency, but a macro level organization of the larger cultural and community environment in which long-term recovery is nested” (White W. , 2008).

Since fostering and developing recovery-oriented systems of care is a priority of SAMHSA’s, the extent to which the addiction profession is prepared for this macro level of organization must be assessed.

Snapshot of the Addiction Profession

Description of the Addiction Profession

The addiction profession workforce is estimated at more than 76,000 individuals (Bureau of Labor Statistics, 2011) that include counselors, educators, and other addiction-focused health care professionals who specialize in addiction prevention, intervention, treatment, recovery support, and education.

Most addiction professionals are employed in the following industries (Bureau of Labor Statistics, 2011):

- Outpatient care centers
- Residential mental retardation, mental health and substance abuse facilities
- Individual and family services
- Local government
- General medical and surgical hospitals
- Psychiatric and substance abuse hospitals
- Private practice

Many other addiction professionals work in prisons, probation or parole agencies, juvenile detention facilities, halfway houses, detox centers, and employee assistance programs (EAPs) (Bureau of Labor Statistics, 2012).

NAADAC members report that about half of the organizational facilities in which members practice are located in urban areas, approximately 30% are in suburban locations, and the remainder are in rural areas. NAADAC members working in private practice are just as likely to work in an urban area as they are in a suburban area: about 42% of members in private practice work in urban areas and another 44% work in suburban areas (NAADAC, 2001).

The average wage for addiction professionals is \$41,030 per year or \$19.73 per hour (Bureau of Labor Statistics, 2011). On average, addiction professionals in private practice earn more income than those who work in organizational facilities (NAADAC, 2001). Addiction professionals hold varying job titles, including but not limited to:

- Administrator
- Addictions Counselor
- Alumni Support Specialist
- Alcohol and Drug Counselor

- Assessment Specialist
- Behavioral Health Managed Care Professional/Executive
- Case Manager
- Chemical Dependency Counselor
- Chemical Dependency Professional
- Clergy
- Clinical Case Manager
- Clinical Supervisor
- Continuing Care Counselor
- Detox Specialist
- Drug and Alcohol Treatment Specialist
- Evaluator
- Health Navigator
- Intake Specialist
- Interventionist
- Outreach Worker
- Peer Mentor
- Peer Recovery Coach
- Professor/Educator
- Professional Clinical Counselor
- Professional Counselor
- Program Manager
- Psychiatrists
- Psychologists
- Recovery Coach
- Social Worker
- Spiritual Care Counselors
- Substance Abuse Counselor
- Tobacco Recovery Counselor
- Volunteer
- Wellness Specialist

NAADAC collected demographics of its membership to provide further details of the profession (NAADAC, 2010):

- 54% of NAADAC members are certified and/or licensed Substance Abuse Counselors, followed by Licensed Professional Counselor (21.6%), Social Worker (13.7%), and Clinical Supervisors (13%).
- 79% of NAADAC members are state certified or licensed as substance abuse counselors. Many members also hold NAADAC sponsored certifications: 16% have obtained the National Certified Addiction Counselor (NCAC I) certification; 17% hold the NCAC II; and 11% have obtained the Master Addiction Counselor (MAC) certification. Overall, 41% of members hold at least one NAADAC-sponsored certification (NAADAC, 2001).
- Almost one-third of NAADAC members are licensed professional counselors (LPC) and another 20% are licensed clinical social workers (LCSW). Approximately 15% are licensed or certified mental health counselors. These professions make up less than 10% of NAADAC's membership base: registered and licensed nurses, licensed clinical

psychologists, licensed marriage and family therapists, prevention specialists, nurses, rehabilitation counselors (NAADAC, 2001).

- 60% state that “Counselor” is their primary job function. NAADAC's members also provide services in a variety of settings, such as private and public treatment centers, hospitals, governmental agencies, and community-based behavioral health agencies.
- Three-quarters (76%) of NAADAC’s members have been in the addiction services profession for more than ten years.
- Women compose 55% of NAADAC’s membership base. Eighty-five percent are Caucasian, 9% are African-American, 1.5% Native American, and 2.6% Hispanic/Latino.
- The addiction profession workforce is aging (SAMHSA, 2012). Sixty-nine percent of NAADAC members are over age 50. Forty-two percent are over 61 years old.

Although founded on a workforce almost entirely comprised of those in recovery from alcohol or drugs, the recovery representation has declined substantially since the early 1970s. It is best estimated that those in recovery currently represent only 25% to 65% of all addiction professionals, with most studies reporting rates in the 30th and 40th percentiles (White, 2009).

Entry-level positions within the addiction profession require a high school diploma or equivalent (Bureau of Labor Statistics, 2012), but most addiction professionals have a college degree or higher. Eighty-four percent of NAADAC members have a Bachelor’s degree or higher, and 63% have a Master’s degree or higher (NAADAC, 2010). Approximately 1/3 of Master’s degrees held by members are in the field of counseling; about 20% are in social work, 10% are in counseling psychology, and another 10% are in psychology (NAADAC, 2001).

Education and training for addiction professionals does not stop with academic institutions. In general, addiction professionals receive “moderate” amounts of on-the-job training to attain competency in the skills needed to perform necessary responsibilities (Bureau of Labor Statistics, 2012) and receive continuing education on an on-going basis. Over 95% of NAADAC members have received continuing education or training in substance abuse over the past year (NAADAC, 2001), and are engaged in regular and ongoing professional development. In many cases, this education and training is related to job expectations and initiatives or to ongoing license or certification requirements.

History of the Addiction Profession and Recovery

To examine the evolution of recovery orientation within the history of addiction profession, NAADAC invited William White, author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, to pen a short essay on this topic. White’s review of the history and future of recovery orientation in addiction counseling appears below.

The addiction profession is historically rooted in the lived experience of recovery, but the degree of recovery orientation among addiction professionals has ebbed and flowed over the course of the field's history. Four overlapping eras illustrate the evolution in the field's recovery orientation. Note: Recovery orientation is defined as respect for recovery-based experiential knowledge, a focus on the facilitation of *long-term* personal/family recovery, adherence to recovery-linked and scientifically grounded service practices, and emphasis on the role of community recovery capital in the initiation and maintenance of personal/family recovery.

Recovery Roots of Addiction Counseling

The birth of a specialized helping role to facilitate the resolution of alcohol and other drug problems can be traced to the first persons recovering from such problems who committed their lives to helping others similarly affected. In the United States, such roles included the leaders of 18th and 19th century Native American abstinence-based religious and cultural revitalization movements and the “reformed” temperance missionaries within the Washingtonian Temperance Society (1840s), recovery-focused fraternal temperance societies (1840s-1870s), the Ribbon Reform Clubs (1870s), and such local recovery mutual aid groups as the Drunkards Club in New York City (Coyhis & White, 2006; White, 2000).

Collectively, these individuals shared their recovery stories in public and private meetings, penned recovery-focused pamphlets and autobiographies, conducted private consultations with individuals and families experiencing addiction-related problems, helped organize local recovery support groups, and maintained prolonged and prolific correspondence with those seeking recovery (White, 1998). The employment of such charismatic recovering figures within the rising network of mid-19th century inebriate homes, inebriate asylums, and private addiction cure institutes marked one of the first controversies and professional splits in the addiction profession. Inebriate homes were often founded and directed by persons in recovery, maintained close links to local recovery mutual aid societies, and emphasized the importance of public commitment (signing the abstinence pledge), sober fellowship, service to others, and the value of short voluntary stays to prime the recovery process. In contrast, inebriate asylums were physician-directed and emphasized physical methods of prolonged, legally mandated institutional treatment that emphasizes medical treatments aimed at cure. Inebriate asylum directors attacked the hiring of “reformed men” on the grounds that:

Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic deficits of the higher mentality.... The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the work any length of time (Crothers, 1897).

The tensions between the inebriate homes, asylums, and institutes; experiential knowledge versus professional knowledge; and recovery support versus medical cure were lost in the larger collapse of addiction treatment and recovery mutual aid groups in the opening decades of the 20th century.

The Addiction Counselor as Paraprofessional Recovery Specialist

The collapse of 19th century addiction treatment in the United States left those with the most severe alcohol and other drug problems abandoned to inebriate penal colonies, the backwards ways of aging state psychiatric asylums, or the “foul cells” of large public hospitals. Those conditions spawned new recovery support efforts, including clinics that trained people in recovery as “lay therapists.” Courtenay Baylor, Francis Bishop, and Richard Peabody were among the earliest and most distinguished of such lay therapists and might well be called the first addiction counselors in the United States. This lay therapy tradition was carried forward by Ray McCarthy and others within the Yale alcoholism clinics of the mid-20th century and the extension of Alcoholics Anonymous sponsors into what were first called “AA counselors.”

The lay therapy tradition was further extended with the hiring of “ex-addicts” in the growing network of therapeutic communities, methadone maintenance programs, and outpatient counseling clinics in the 1960s and early 1970s. This emerging “paraprofessional” counselor role incorporated multiple dimensions - the tradition of recovery storytelling (self-disclosure), mutual recovery support, counseling (new skills incorporated from the fields of psychiatry, psychology, and social work), and community recovery resource development and linkage (White, 1998; 1999). The paraprofessional era was marked by high recovery representation within the addiction treatment workforce, close linkages between treatment and local recovery communities (particularly AA), and an emphasis on experiential versus professional/scientific knowledge. The primary and sometimes exclusive credentials the paraprofessional addiction counselor brought to his or her role were personal recovery and a passion to help others recover (White, 1998; 2009).

Professionalization of Addiction Counseling

The professionalization of addiction counseling unfolded within the emergence of a specialized, revitalized field of addiction treatment—the growth of local treatment programs; formally designated state and federal agencies responsible for planning, funding, and evaluating treatment programs; the extension of insurance coverage for the treatment of alcoholism and other addictions; the rise of hospital-based and private addiction treatment programs; and the emergence of addiction treatment program licensure and accreditation standards. To achieve public and professional credibility, this rebirthed field required an expanded and credentialed addiction counseling workforce.

Two milestones significantly shaped the addiction counselor role. First, addiction treatment migrated toward an acute care intervention (modeling itself on the hospital via early accreditation standards) rather than on the models of more extended recovery support that prevailed during the paraprofessional era. Second, the role of addiction counselor was modeled on clinical functions performed by psychiatrists, psychologists, and social workers. Notably, key functions were lost in this transition (e.g., assertive outreach and linkage to indigenous recovery supports in the community). The core functions of the addiction counselor narrowed (screen, assess, diagnose, treat/counsel, document, discharge), and substantial state and federal resources were invested in skill development related to these core functions. The professionalization of addiction counseling

was also marked by the rise of national and state associations for addiction counselors, the development of certification and licensing standards for addiction professionals (with increased educational requirements), the proliferation of preparatory addiction studies programs in colleges and universities, new resources for continuing education, and improved salaries and benefits for addiction counselors.

The 1970s and 1980s marked the transition of the addiction counselor from the status of paraprofessional to that of a clinical professional on par with other recognized helping roles. Rarely noticed during this period of explosive growth was the decline in recovery representation in the addiction treatment workforce and among executive leadership and governing boards, the erosion of once strong volunteer and alumni programs, weakened connections to local communities of recovery, and a shift in orientation from long-term recovery to ever-briefer periods of treatment. Cyclical episodes of bio-psycho-social-spiritual stabilization became the norm with a growing portion of persons entering treatment with multiple prior admissions. Throughout the 1990s there was a sense of great pride in how far the addiction profession had come in a few short decades, but underlying unease remained that things of great value had been lost in the professionalization, industrialization, and commercialization of addiction treatment (White, 2000).

The recovery advocates of the 1940s to 1960s spent much of their lives advocating for federal legislation that in the early 1970s established the foundation of modern addiction treatment. They did so on the belief that specialized addiction treatment could provide a portal of entry into recovery for people who could not otherwise initiate or sustain recovery. By the mid-1990s, there was a growing sense among a new generation of recovery advocates and many long-tenured addiction counselors that the multibillion-dollar addiction treatment industry had become disconnected from the larger and more enduring process of addiction recovery and from the grassroots communities whose efforts had birthed the field (Else, 1999; Morgan, 1995; White, 2002; 2004).

Recovery Renewal

Several contextual conditions set the stage for calls to renew long-term recovery as the central mission of addiction treatment and addiction counseling (Dennis & Scott, 2007; Kelly & White, 2011; McLellan, Lewis, & O'Brien, 2000; White, 2005; 2008; White, Kelly, & Roth, in press; White & McLellan, 2008):

- The growth and diversification of recovery mutual aid organizations;
- A new recovery advocacy movement that both supported addiction treatment and challenged its diminished recovery orientation;
- The emergence of new recovery support institutions as adjuncts and alternatives to addiction treatment;

- A growing body of research findings on the limitations of the acute care model of addiction treatment;
- The reconceptualization of addiction as a chronic disorder; and
- Increasing calls to shift treatment of the most severe and complex addiction problems toward a model of sustained recovery management.

It was perhaps inevitable in the face of such changes that the profession's organizing center began to slowly shift from its historical focus on addiction pathology and the mechanics of treatment to rising interest in the prevalence, pathways, and processes of long-term personal and family recovery.

Fulfilling the current vision of recovery-focused addiction treatment and addiction counseling will require substantial changes in the field's infrastructure (McLellan, Carise, & Kleber, 2003), service practices (White, 2008), and evaluation methodologies (McLellan, 2002):

- Recovery-oriented addiction treatment/counseling will require authentic and diverse personal/family recovery representation at all levels of decision-making within the addictions field.
- Major efforts at workforce stabilization and recovery-focused education and training of addiction professionals will need to be undertaken to ensure that each individual/family seeking help will have continuity of contact in a primary recovery support relationship over the course of long-term recovery.
- The diverse pathways and styles of long-term addiction recovery will need to be carefully mapped, and addiction professionals will need to be knowledgeable of the growing varieties of recovery experience and recovery cultures.
- Recovery-focused addiction counseling would extend the goal of acute bio-psycho-social-spiritual stabilization to encompass pre-treatment recovery priming (assertive outreach and engagement) and support for post-stabilization transitions to recovery maintenance, enhanced quality of life in long-term recovery, and family-centered interventions to break intergenerational cycles of problem transmission.
- Patients/families seeking addiction treatment would be routinely informed of independently verified program and modality specific recovery outcomes (remission and survival rates), as well as the frequency of iatrogenic risks (harmful side-effects) - in the same way patients are today informed of such risks in life-invasive medical procedures for the treatment of cancer or heart disease.
- Recovery-focused assessment activities would move beyond assessment of individual addiction pathology as an intake activity to comprehensive (using global assessment

instruments), strengths-based (focusing on the evaluation of personal, family, and community recovery capital), and continual assessment activities.

- Individuals and families once channeled into pre-packaged “programs” would have access to an ever-expanding menu of recovery-focused, science-grounded services/supports - including a broad spectrum of primary and behavioral health care services - that would be personally matched, combined, sequenced, and adequately dosed to maximize their effects on successful recovery initiation and long-term maintenance.
- Multi-disciplinary, multi-agency service models with inclusion of culturally indigenous institutions and healers would become the norm for treating the most severe substance use disorders.
- The service relationship would shift from an expert model toward a partnership model of long-term recovery support.
- The emphasis on professionally-directed treatment planning would be extended to person-directed recovery planning - both processes guided by personal/family choice (White, 2008) with interim outcomes carefully monitored and communicated to inform continued treatment and recovery support decisions (McLellan, et al., 2005).
- Service delivery for addiction professionals would be extended far beyond specialty sector addiction treatment programs, with addiction professionals working within a broad spectrum of healthcare, educational, business, military, religious, social service, sports, and media settings. Great emphasis would be placed on reaching and serving people within their natural environments using both face-to-face and technology-facilitated support.
- Continuing care as an afterthought in addiction treatment would give way to an emphasis on sustained post-treatment recovery checkups (for at least 5 years for everyone admitted to addiction treatment regardless of discharge status), stage-appropriate recovery education, assertive linkage to recovery mutual aid groups and other indigenous recovery support institutions, and if and when needed, early re-intervention (Dennis & Scott, 2012).
- The distinctive clinical orientation of addiction counselors would be expanded to cover community assessment and recovery resource development and mobilization (White, 2009). Some addiction professionals would work in specialized roles aimed at the expansion of family and community recovery capital and building bridges of collaboration between professional addiction treatment organizations and the growing networks of recovery mutual aid organizations and other recovery support institutions.

Efforts to increase the recovery orientation of addiction treatment/counseling are underway across the United States under the conceptual rubrics of recovery management and recovery-oriented systems of care, including many of the suggestions above. The success or failure of these efforts will exert a powerful influence on the future of addiction recovery in America and the fate of specialty-sector addiction treatment as a cultural institution.

Assessment Methodology

In order to develop a relevant training curriculum that will reflect the current needs of the addiction profession, NAADAC conducted a systematic needs assessment of existing knowledge, skills, competencies, attitudes, practice levels, and change readiness in relation to recovery and recovery concepts.

Qualitative and quantitative measures were employed for this Situational Analysis and the following indicators were assessed:

- Level of knowledge and understanding of the concept of addiction recovery
- Familiarity with and level of knowledge of recovery-oriented practices
- Attitudes about and experiences with recovery-oriented practices
- Frequency and extent of use of recovery-oriented practices
- Availability of recovery-oriented training opportunities and resources
- Inclusion of recovery concepts in state licensure/certification requirements for addiction professionals
- Frequency of recovery-oriented language in formal documents and marketing materials
- Consistency between formal and informal policy and practice regarding recovery concepts
- Inclusion of recovery concepts in professional journals for the addiction profession
- Readiness of the addiction profession to change
- Areas of improvement for the integration of recovery concepts

Qualitative Strategies

The qualitative strategies used to assess existing knowledge, skills, and/or competencies, attitudes, practice levels, and change readiness regarding recovery-oriented practice included:

- A literature review of addiction-related publications, journals, books, and articles by utilizing online research databases and consultants.
- Discussions and collected written responses from 42 key informants and organizations representing the following sectors of the addiction profession:
 - Administration
 - Continuing care
 - Correctional facility treatment programs

- Detoxification programs
 - Hospitals
 - Inpatient hospital programs
 - Intensive outpatient programs
 - Intervention services
 - Managing entities
 - Outpatient treatment programs
 - Peer recovery support services
 - Prevention
 - Residential treatment programs
 - State associations
- Discussions in two listening sessions during NAADAC’s Advocacy in Action Conference in Washington, DC. Members of the NAADAC RTP Team organized two breakout sessions offered at different times during the conference and open to all attendees. Approximately 67 individuals participated between the two sessions, which consisted of NAADAC leadership, NAADAC members, addiction and other helping professionals, consumers (persons in recovery or/and family members) and other conference attendees.
- Comments from 164 consumers (persons in recovery and family members) and addiction professionals in an open call for feedback on the NAADAC website, representing these sectors of the addiction profession:
- Administration
 - Behavioral health programs
 - College/University
 - Community mental health/Substance abuse agency
 - Consumers
 - Continuing care
 - Criminal justice system
 - Detoxification programs
 - DUI and drug diversion agency
 - Employee assistance programs
 - Hospital/Medical center
 - Inpatient hospital programs
 - Intervention services
 - Intensive outpatient programs
 - Local/State/Federal agency
 - Managed care
 - Methadone outpatient treatment center
 - Military
 - Non-profit
 - Outpatient treatment programs
 - Peer recovery support services
 - Physicians health
 - Prevention
 - Private practice
 - Residential treatment programs
 - Sober housing
 - State associations
 - State HIV care sites
 - Students
 - Workforce development/Credentialing
- The review of the policies and approaches of nine major addiction-related professional associations:
- NAADAC, the Association for Addiction Professionals
 - American Society of Addiction Medicine (ASAM)
 - Faces and Voices of Recovery
 - International Certification & Reciprocity Consortium (IC&RC)
 - NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies
 - National Association of Addiction Treatment Providers (NAATP)

- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- State Associations of Addiction Services (SAAS)
- Treatment Communities of America (TCA)
- An assessment of the educational program offerings of 11 major addiction-related professional conferences:
 - NAADAC, the Association for Addiction Professionals
 - American Association for the Treatment of Opioid Dependence, Inc. (AATOD)
 - American Society of Addiction Medicine (ASAM)
 - International Certification & Reciprocity Consortium (IC&RC)
 - Joint Meeting on Adolescent Treatment Effectiveness (JMATE)
 - National Council for Community Behavioral Healthcare (NCCBH)
 - NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies
 - National Association of Addiction Treatment Providers (NAATP)
 - National Association of State Alcohol and Drug Abuse Directors (NASADAD)
 - National Conference on Addiction Disorders (NCAD)
 - State Associations of Addiction Services (SAAS) Annual Conference and NIATx Summit
- Examination of formal communications (e.g. websites, brochures, press releases, newsletters, campaigns, board and other meeting minutes), staffing and job descriptions, scopes of practice, practice guidelines, treatment algorithms, and ethical guidelines employed by eight addiction treatment providers and organizations:
 - Connecticut Association of Addiction Recovery Resources (CAARR)
 - Hazelden
 - Pretera Center for Mental Health Services, Inc.
 - Rhode Island College Institute For Addiction Recovery
 - Valley HealthCare System
 - ValueOptions, Inc.
 - WestBridge Community Services
 - Willamette Family, Inc.
- Review of course offerings and syllabi from academic institutions that are approved by the National Addiction Studies Accreditation Commission (NASAC) and NAADAC's Approved Academic Education Provider Program for recovery-related coursework.
- Examination of documents and training materials of four addiction agencies/boards:

○ Connecticut	○ Michigan
○ Maryland	○ Philadelphia
- Assessment of recovery-focused training and technical assistance offered by institutional training curriculums, graduate or professional training programs, state mental health agencies, and other organizations.

- Review of state and national licensure or certification requirements for the addiction profession.

Quantitative Strategies

The quantitative strategies used to assess existing knowledge, skills and/or competencies, attitudes, practice levels and change readiness included:

- *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice Technical Assistance Publication (TAP) Series 21* by Substance Abuse and Mental Health Administration (SAMHSA)
- *Competencies for Substance Abuse Treatment Clinical Supervisors Technical Assistance Publication (TAP) Series 21-A* by Substance Abuse and Mental Health Services Administration (SAMHSA)
- *Performance Assessment Rubrics for the Addiction Counseling Competencies* by Northwest Frontier Addiction Technology Transfer Center (ATTC)
- *Occupational Outlook Handbook, 2012-13 Edition* by the Bureau of Labor Statistics, U.S. Department of Labor
- NAADAC In-House Data (Membership Survey; State Certification/Licensure Inquiry; Education Inquiry)
- *Practitioner Research Network Final Report* by NAADAC
- *Developing and Financing Recovery Support Services: Linkage with Healthcare and Substance Use Disorder Services* prepared for the Department of Alcohol and Drug Programs, California Health and Human Services Agency
- *State Regulations on Substance Use Disorder Programs and Counselors: An Overview* by NASADAD

Contextual Conditions for the Addiction Profession

The addiction profession is at a point when the old traditions of treatment as a stand-alone event will move to a more comprehensive continuum of care and support. Some will argue that the field already has that full continuum of services. It is true that there are pockets of a continuum that begin with pre-treatment and support to treatment, to continuing care with some alumni services or other recovery supports. In fact, the profession is moving away from the crisis oriented, acute care, and clinically driven model to a long-term model of care that includes ongoing support, treatment as part of the model, and recognition that there are many pathways to recovery. However, the economic, political, social, and technological mechanisms for this full range of care have not been applied system-wide.

Following are some of the internal and external forces that will inform policy and practice, some taken from the literature and others from interviews and responses to inquiries. It is a snapshot of how the addiction profession views the field today.

Economic Strengths

Upon reviewing the literature and speaking to key informants within the addiction profession, many economic strengths for implementing a recovery-oriented model of care were identified.

Various Funding Sources

In a recently published report titled *Developing and Financing Recovery Support Services: Linkage with Healthcare and Substance Use Disorder Services*, the authors found that there are a variety of funding streams from public and private funding that have developed means to fund recovery support services (Rawson, Cousins, & Pearce, 2011). For example:

- Some states are using Medicaid waivers to include recovery support services.
- State addiction agencies in Connecticut, Georgia, Florida, Michigan, and Arizona are using state funding to encourage the adoption of recovery-oriented practices among local addiction programs. It is likely that more states will be moving in this direction.
- Two states are using the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant to fund services, and 11 states used the 2007 ATR grants to fund previous implementation of recovery-oriented services. Some recipients of the 2010 ATR grant said that funding is being used to continue with further implementation and the expansion of these services (Harwood, 2012).

A summary of recovery support services (RSS) funding mechanisms is below (Abt Associates Incorporated, 2010):

Summary of Funding Streams and Provision of Recovery Support Services (RSS)

Funding Streams	Description	Provision of RSS
Medicaid	The Medicaid program operates as a partnership between Federal and State governments to provide health coverage to certain low-income individuals and families. Each State operates its own Medicaid program, with unique eligibility guidelines and benefits packages approved by the Federal Government. While treatment for substance use conditions is not a mandatory benefit under Medicaid, the majority of States have amended their Medicaid State plans to cover treatment and some RSS.	Medicaid allows the provision of RSS through the waiver processes described below and by State plan amendment.
Medicaid Rehab Option	Under the rehab option, States can cover “other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other institution) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”	States are required to identify what specific services will be offered as a part of the program and obtain CMS approval for these services. There is flexibility in that services can be delivered in a variety of locations by a wide range of professionals. The current exclusions are room and board, transportation, and vocational/educational training.
Medicaid Managed Care/Freedom of Choice Waivers	A Medicaid section 1915(b) or “freedom of choice” waiver allows States to implement managed care systems for Medicaid beneficiaries. These waivers are used by States to operate programs that affect the delivery system for some or all of the individuals eligible for Medicaid in a State.	There are no specific instructions on what services can be included. There are two limitations listed: (1) they cannot negatively impact beneficiaries’ access to care, and (2) offering the services cannot cost more than the program would have cost without the waiver. This guidance still provides States with flexibility in determining what services should be offered to best meet the needs of individuals.
Medicaid Deficit Reduction Act	The DRA allows States greater flexibility to furnish community-based services, including RSS, through Medicaid. States have the ability to provide home-based and community-based services to elderly individuals and people with disabilities without requiring a waiver or demonstrating cost-neutrality. States can provide any of the services now covered under Home and Community Based Services (HCBS) waivers. DRA also expands services to populations not previously eligible for HCBS waivers and allows States to tailor HCBS to the needs of a particular population.	States can offer a range of support services, including financial management, personal development, advocacy, crisis management support, skills training, coordination/linkages with other resources, and peer support services. These services can be provided one-on-one, in groups, in community institutions, or in the individual’s natural institution/home.
SAPT Block Grant	The SAPT Block Grant provides foundational support to States for prevention and treatment services and activities. SAPT Block Grant recipients are given considerable flexibility to determine how to spend funds on “treatment activities,” which is broadly defined and could include RSS. In addition, the importance of services that constitute RSS is emphasized both in the SAPT Block Grant section of the law and in regulation.	The SAPT Block Grant requires the provision of RSS to an identified population, pregnant women and women with dependent children. Block Grant language specifically states that agencies providing treatment services must also offer prenatal care and childcare to women with dependent children. SAPT Block Grant funds may also be used to help establish group homes for recovering individuals with substance use conditions. Section 300x28(c) requires the coordination of additional services to aid individuals in the areas of health, social, vocational, educational, criminal justice, and

		employment, although there is no specific guidance. Designated States are required to provide HIV pretest and posttest counseling.
ATR	ATR is a discretionary grant program funded by SAMHSA/CSAT, which provides individuals with vouchers to purchase treatment for substance use conditions and RSS at the provider of their choice. The three goals of the program are to expand consumer choice, to track and improve outcomes and, to increase capacity. ATR also aims to include more faith-based and community-based providers in service delivery. RSS are delivered by staff, peers, and volunteers in the community to promote a drug-free lifestyle.	Allowable services include family services (marriage education, parenting, and child development services), child care, individual services coordination, transportation, employment services and job training, HIV/AIDS education and services, supportive transitional drug-free housing services, other case management services, continuing care, relapse prevention, recovery coaching, self-help and support groups, spiritual support, other continuing care service, substance abuse education, and peer coaching and mentoring.
RCSP	RCSP is a program designed specifically to deliver peer support services. These services are not related to treatment and are not provided by professionals at treatment agencies unless these professionals identify themselves as peers and function only in that capacity. RCSP promotes the healthy community by helping the individual achieve and maintain a drug-free lifestyle. The program builds on the premise that individuals in recovery are a valuable resource.	Allowable services include peer-led recovery support groups and meetings, recovery coaching or mentoring, peer case management, recovery education, life skills training, health and wellness training, education and career planning, leadership skills development, and alcohol- and drug-free social and recreational activities.
State and Local	States are funding RSS within their overall service continuum to promote health and wellness. By demonstrating need and benefit to legislators, State agencies have been appropriated funds to expand RSS. States have begun to offer additional supports to individuals before, during, and after treatment. Additionally, States are extending the length and the range of RSS options as a way to promote ongoing recovery.	The types of services provided, target populations, services requirements, and availability of funding vary from State to State.
TANF	The TANF program is a Federal block grant administered by the Office of Family Assistance within the U.S. Department of Health and Human Services, which funds States to provide temporary assistance to aid individuals in gaining employment and achieving self-sufficiency. The TANF Final Rule indicates that States may offer “pro-family” expenditures to individuals in order to meet the overarching TANF goals of reducing out-of wedlock births and increasing the number of two-parent families. The “pro-family” expenditures can be provided regardless of family income and composition.	“Pro-family” activities are consistent with RSS offered through other funding streams (e.g., child care, transportation, family counseling, peer supports).
Drug Courts State and Local Funding	State drug courts often combine resources from Federal, State, and local revenue streams to fund the program. This approach allows greater flexibility in designing the services to be included in the program. State drug courts recognize the importance of including RSS in programs to better assist individuals in achieving and maintaining recovery.	States often have flexibility in designing the components of their drug court program to include RSS when using local resources.
Drug Courts SAMHSA Funding	SAMHSA partnered with the Federal Department of Justice (DOJ) /Bureau of Justice Assistance to fund drug courts. The purpose of this program is to expand and/or enhance treatment for substance use conditions services in “problem solving” courts, which promote treatment for substance use conditions and RSS to aid individuals in accessing treatment services.	The program allows States to fund wraparound services/RSS to participants to aid them in accessing treatment and remaining in treatment. The wraparound services/RSS may include child care, transportation, vocational training, educational training, etc.

Drug Courts DOJ Funding	The Drug Court Discretionary Grant Program, administered by DOJ, awards grants to State, local, and tribal governments up to \$200,000 to establish or enhance their drug court programs. The Bureau of Justice Assistance within DOJ developed a drug court resource guide outlining key components of a drug court program to aid States in developing these services. This guide outlines the effectiveness of providing treatment for substance use conditions to nonviolent offenders involved in the drug court system. Key Component #4 in the guide also outlines the need for additional supports to aid the individual and reduce recidivism: “Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.”	Allowable services include housing; educational and vocational training; legal, money management, and other social service needs; cognitive-behavioral therapy to address criminal thinking patterns; anger management; transitional housing; social and athletic activities; and meditation or other techniques to promote relaxation and self-control.
Private Funding	Some State and local agencies use private donations and foundation grants to help fund RSS.	States may have the flexibility to design which RSS are offered depending on the funding source and the requirements associated with the funding.

The above chart is helpful in identifying potential sources of revenues to fund ROSC/RM (Recovery Management) systems. There are several areas to explore and discover as the addiction profession shifts to this new paradigm in order to make use of the full potential of the various funding streams:

- Include recovery support services in the state Medicaid plan. It will be important that recovery support services are clearly defined in the “essential benefits” package in some way or it will be difficult to ensure that they will be covered in the current parity legislation. Inclusion will offer sustainability for the system as implementation of recovery concepts moves forward. Legislatures and the public, ultimately, are looking for reduced costs in medical care, including addiction services.
- Encourage the continued use of ATR funds to continue implementation of recovery-oriented services.
- Technical assistance regarding methods to secure these funds, along with the expectations for service implementation documentation and evaluation.
- Building local level funding streams and collaborative supports (e.g., community mobilization model).
- Reduction of barriers at the federal and state level that limit counties ability to utilize funding mechanisms such as Medicaid.
- Altering of the SAPT Block Grant to authorize the purchase of recovery support services for substance use disorders.
- Technical assistance regarding the current healthcare reform act and how it is projected to impact current funding.

- States with well-developed recovery-oriented models of care may create learning communities to mentor states/communities that are in the development stages.

Reduced Costs and Improved Outcomes

The advent of SAMHSA's Access to Recovery (ATR) and the Recovery Community Services Program (RCSP) grants fostered the current recovery to practice process. Through grants to non-traditional providers and support service contracts with non-profit, faith-based, tribal, and community groups, these programs created a new venue for treatment and recovery support services. This systems change to recovery-oriented approaches has decreased costs and expanded access and services.

These savings are demonstrated through a number of factors:

- The findings are showing less demand for inpatient care through ongoing peer supports in the community. ROSC and Recovery Management (RM) models provide cost-effective outcomes through expansion of lower levels of care (e.g., earlier intervention) and reduces post-treatment clinical deterioration and program re-admissions as a result of mechanisms such as recovery check-ups and booster sessions.
- RM/ROSC mobilization of indigenous recovery support resources in the community may be a compliment where addiction treatment services may be reduced or closed due to funding cuts resulting from fiscal austerity.
- Expansion of recovery support services is being funded in some areas without new dollars, (e.g., from savings generated by assertive recovery management of high service utilizers). Some states and cities are funding recovery support services within agencies outside specialty sector addiction treatment (e.g., recovery community organizations, faith-based recovery ministries, health care clinics, and other types of clinics), a trend likely to increase via health care reform (Kirk, 2011).
- Replicable service models and funding strategies are available in the Connecticut and Philadelphia models (Kelly & White, 2011).

MCO and BHMCO Activity

Several managed care organizations (MCOs) and behavioral health managed care organizations (BHMCOs) are now funding recovery support services and peer recovery support specialists in several states (e.g., Arizona, California, Maryland, Pennsylvania, Texas, Florida, Kansas, and New Mexico). There are several innovative ways that MCOs/BHMCOs can reimburse for ROSC activities, such as through a bundled case rate rather than as fee for service, outcomes and pay for performance-based reimbursement, voucher based reimbursement, funding-follows-the-person, and capitation. Some of these services are developing within current treatment structures and other services are developed through ROSC service centers. These are beginning models of services that are expected to grow.

There is promising news in that companies like ValueOptions and other BHMCOs have dedicated departments for Recovery and Resiliency staffed with people in recovery and family members. A key role for these departments is to help link members to community based and funded services to aid in recovery and wellness. Recovery and Resiliency departments at BHMCOs will likely be strong allies in the development of recovery support networks, serving as conduits between clients, advocacy groups, communities, and the BHMCOs.

Economic Barriers

Even though there are many economic strengths, several economic barriers to implementing a recovery-oriented model of care were also identified.

Funding and Regulatory Rules are Built on an Acute Care Model

Addiction treatment was initially structured to follow medical models that were adapted from standards for acute-care hospital settings with reviews by The Joint Commission (and later CARF). These standards were specific to client inpatient care and later outpatient/intensive outpatient treatment models. “After care” services usually did not extend beyond a referral to a mutual support group (most often 12-Step based). In order to move from an acute care model to a recovery model, it will require more than conceptual alignment; it will require changes in key service practices, which are dependent upon changes in the current funding policies and mechanisms.

Most often, federal, state, and local government funding is limited with certain conditions for performance attached that often do not include a long-term recovery model of care. Many of these requirements follow the managed care model. The focus tends to be short-term care with expectations that certain “markers” are attained, such as abstinence from alcohol and other drugs, employment or enrollment in school, decreased criminal involvement, safe and stable housing and social connectedness (SAMHSA’s National Outcome Measures). It is also built on an acute-care model of intervention often beginning with a screening/assessment and moving to a short-term, time limited treatment program that is terminated without regard to community ongoing supports (Steenrod, Brissom, McCarty, & Hodgkin, 2001).

Treatment programs that receive the federal, state and local funding are mandated to follow certain protocols to receive the funding, including length of stay and program delivery terms. Outcomes for services are collected and continued funding is usually determined by the treatment program meeting outcome requirements. The current structure in most states does not allow for a “recovery oriented system of care” model.

Addiction treatment services that are delivered and reimbursed are primarily through the following modalities: inpatient, social or outpatient detoxification; short-term inpatient or residential treatment; long-term inpatient or residential treatment; methadone maintenance treatment or other medication-assisted treatments; and outpatient treatment (intensive or continuing care). These programs are funded through federal, state and local government funds

(including Medicaid), insurance reimbursement, private or self-pay, other organizations (church, community funds, private foundations or other grants) (Rodgers & Barnett, 2000; Wheeler & Nahra, 2000; Wheeler, Fadel, & D'Aunno, 1992). Recovery-oriented services are not currently reimbursable through all of the Single State Authority (SSA) agencies. In some cases, the SSA does reimburse through state general funds, special projects, and, of course, through the block grants and discretionary grants, but it is becoming less prevalent due to state funding challenges.

Reductions in Funding

Another barrier is that as efforts are underway to create and expand recovery-oriented systems of care, funding is being cut. With the Affordable Care Act being upheld in the Supreme Court, there lies hope. It is this time between the funding and regulatory changes and the current funding cuts that will determine the sustainability and survival of existing treatment programs. The addiction treatment infrastructure has been reduced and has felt the strain of the economic crisis in America these past five years.

The rates of closure even before the economic crisis are alarming at 15% and re-organization at 29%, both over a two-year period of time (McLellan, Carise, & Kleber, 2003). In 2004, it was reported that the number of specialized addiction treatment programs dropped from more than 16,000 in 1990 to 13,200 (McLellan & Meyers, 2004). These numbers do not reflect the current economic downturn suffered in the US.

Inadequate Funding for Start-Up of ROSC Systems

Currently, there are not adequate funding mechanisms widely available to implement and sustain recovery-oriented systems of care. According to direct feedback from addiction professionals, most addiction professionals and agencies favor recovery-oriented systems of care, but many cannot afford full adoption. For example, many addiction treatment facilities are understaffed; therefore, budget allocations for peer recovery support specialists or alternative therapies are difficult to obtain. In addition, there is insufficient trained staff available to fill these needed staff positions.

Funds for community supports including transportation, childcare, shelter, food vouchers, and other supports are lacking (NAADAC, 2011). Some treatment centers implement programs for on-going alumni and family support to help connect the graduating client and their family members to community supports. Other treatment programs collaborate with local non-profits that provide these services to individual and families (Volunteers of America, Salvation Army, Goodwill, church and other philanthropic organizations or service clubs such as Kiwanis, Rotary, Lions, Elks, and others).

Further, many addiction professionals report that the current depressed economic climate as a whole is affecting spending attitudes. With limited resources pulled in several directions, many addiction professionals struggle to prioritize what services and expenditures are essential to survival, especially if there are no other funding streams available to provide for the expanded services.

Given that funding for continuing education is increasingly scarce and fee-based clinicians cannot get reimbursed for these activities, access to education is suffering. Addiction professionals are increasingly unable to attend face-to-face trainings or participate during office hours, making it harder to receive recovery-oriented continuing education.

Consumers Concern for Insurance Reimbursements

There were comments made regarding the lack of insurance reimbursements for treatment services, especially in the non-hospital sub-acute residential setting where longer-term treatment and recovery support is available. Concerns were voiced that “parity” has not really come into play even though the law has been passed. There is a need for advocacy for the consumer and their family members to receive long-term services and support when identified. The issue of stigma is still alive in the general community regarding addiction, especially for the person addicted to “hard drugs”, like heroin, meth and other drugs. The terminology that consumers and professionals alike use to describe the person who is addicted; “addict” is one to be considered in the context of perpetuating stigma.

MCO’s Concern for ROSC Programming

Arguments against the ROSC model and MCO/BHMCO’s funding them include:

- The quality of service cannot be monitored easily because there are not standardized evaluation outcome expectations.
- Outcomes cannot be determined unless the philosophy changes from using treatment completion as an outcome to using “quality of life” measurements. Note: The World Health Organization (WHO) has accomplished this shift with their WHOQOL tool for mental health, which can be adapted for use within the addiction profession.

Insurance Companies and Third Party Reimbursement

Some addiction professionals perceive insurance reimbursements for services rendered to be too low and not commensurate with the skills and education now required. There is a pattern among insurance company practice to limit covered days and covered services and release a patient from addiction treatment before they are ready *for* recovery. They are not allowed to take the time needed to grasp the *possibility* of recovery for them. Some addiction professionals have disengaged in the process that shapes rates or lack understanding of how utilization management works so they can advocate for their insurance claims. Increased communication between the providers and insurance companies could help to shape the decisions and reimbursement rates that insurance companies use.

Parity has not yet been fully implemented in all states. Many providers report that there is “no teeth” in the law, as insurance companies are not monitored to ensure compliance with the law.

Mental Health and Behavioral Health

A deep concern of the addiction profession is that addiction-specific services will be subsumed by mental health as service delivery is re-shaped and combining addiction services into mental health services. Addiction professionals are concerned that this reduction in specificity will reduce funding, treatment, and public awareness of addiction as a disease. The other concern lies in the heredity factor of addictive disorders and that being lost in the viewing addiction as a “mental issue.” It is important to recognize that addictive disorders are inherited, and as a result of this “intergenerational inheritance,” some individuals will have a genetic predisposition to developing substance use disorders.

Use of the term “behavioral health” to include addictive disorders is *also* viewed as several steps backward by many in the addiction profession. Addiction-focused professionals view addictive disorders as a bio-psycho-social-spiritual disorder that has behavioral components rather than a behavioral disorder that could be managed “at will” by the client. The term detracts from the science of addiction.

Further Considerations

To ensure progress for the profession and for clients, the addiction treatment field must begin with a model of recovery-oriented supports. The critical component as recovery support is implemented is to ensure that there is accountability and cost controls as the programs are introduced, and that this process is balanced with the needs of the consumer and their family member(s) as he or she progresses through the recovery process. It is critical that as funding increases in care, that the requirements to evidence positive outcomes not outweigh the need for an effective recovery experience for consumers. Including the family member (as defined by the person in recovery) as a critical component of recovery care has been shown to reduce medical case costs for family members within the first year, and thereafter, the reduction per year of expenses grows. The family entering treatment is the key to long-term bio-psycho-social-spiritual recovery for both the individual and all family members involved (Weisner, Parthasarathy, Moore, & Mertens, 2010). As recovery oriented systems of care are more widely implemented, short and long-term results need to be accounted for given the chronic diseases of addiction.

Political Strengths

Upon reviewing the literature and speaking to key informants within the addiction profession, many political strengths for implementing a recovery-oriented model of care were identified.

Professional and Recovery Strength

The Addiction Leadership Group (ALG) that was created over 20 years ago, comprised of national addiction organizations (Legal Action Center, NASADAD, Center for Science in the Public Interest, NAADAC, SAAS, TCA, NAATP, ASAM, Faces and Voices of Recovery, National Council for Community Behavioral Healthcare, National Association for Children of Alcoholics (NACoA), Capitol Decisions, IC&RC, and CADCA), has built a strong education/advocacy effort with targeted public policy initiatives and funding allocation

recommendations. These national organizations are able to extend their reach with grassroots efforts through their national offices to build influence in Washington, D.C., as well as at state and local levels.

NAADAC, the Association for Addiction Professionals, has been a leader in advocacy, beginning its first national structured advocacy effort in 1986, and creating an addiction-specific political action committee (PAC) over 25 years ago. NAADAC Public Policy Statements and White Papers have influenced legislators in areas such as ATR funding, opioid medication waiver increase, the Second Chance Act, parity, the Patient Protection and Affordable Care Act, and other public policy initiatives. Continuous visits to Capitol Hill, with constituents, stakeholders, and the NAADAC Government Relations Department have kept caucuses, committees, and legislators informed on pertinent addiction and recovery issues.

The addiction profession, along with individuals and families in recovery and recovery organizations, has joined efforts in the National Recovery Month initiative that was begun over two decades ago by NAADAC as the *Treatment Works* campaign. This growing effort has raised the profile of addiction and mental health recovery by emphasizing that recovery initiatives are worth the time, effort, and dollars to foster recovery within individuals, families, and communities. Visibility and political power of the recovery advocacy movement is growing, with more than 100,000 people involved in recovery events in September 2011.

According to a recent survey released on March 6, 2012, The Partnership at Drugfree.org and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) estimate that 10% of American adults consider themselves to be in recovery from drug or alcohol abuse problems (The Partnership at Drugfree.org, 2012). There is a growing social capital of recovering persons that can add to political advocacy if made aware how to engage in the process. Organic connections from treatment programs to recovery advocacy could be built either in a non-structured referral system or a more structured alumni system. Organizations such as Faces and Voices of Recovery, NCADD, and Legal Action Center have focused on helping recovery advocates become more skilled and effective through training, coaching, and consultation support. As awareness and encouragement of recovery support grows, addiction professionals will be trained in the ROSC and RM models that will increase awareness and advocacy to support the sustainability of this model.

New Legislation

Now that the Patient Protection and Affordable Care Act (ACA) was upheld by the Supreme Court, many changes can be expected in the addiction and mental health treatment and recovery systems. A NAADAC position statement issued after the Supreme Court's ruling identified four areas that will have impact on the addiction profession:

- Broader coverage for Americans with substance use disorders, with about five million people meeting medical diagnostic criteria for a substance use disorder;

- No denial of coverage for pre-existing conditions;
- Plans must cover substance use disorders if the insurance plan covers other chronic medical disorders; and
- Greater access to treatment through Medicaid (NAADAC, 2012).

Regulation Changes

SAMHSA has affected change in the SAPT grant structure for states to be able to build recovery-oriented systems of care.

Single State Authorities (SSAs) and state legislators are beginning to change their own state regulations to be more inclusive of ROSC and RM model as previously reported in this document.

There are more system-level regulations that require consumer representation on federal, state or community addiction governing boards.

Political Challenges

One cannot only focus on the strengths in the political world, but rather also consider the challenges impeding the implementation of a recovery-oriented model of care.

Bureaucratic Challenges

Change within any system is a challenge, and the bureaucratic system is no different in that respect. Decision makers are required to judge the merits of new methods of reimbursement and new ways of doing business from a multitude of perspectives. Consequently, it may take an extended period of sustained education, a shifting of political will, and data showing positive outcomes to implement the recovery-oriented system that is envisioned. National, state, and local elections often pivot upon a candidate being seen as someone who supports positive change and is part of successful endeavors related to improving the lives of constituents. Reaching out to political decision makers is vital to gaining their support for recovery-oriented efforts. Frequently, changes in service practices are imposed that are incongruent with scientific evidence and efforts to increase recovery orientation, such as lack of funding to support recovery residences, imposition of time limits on treatment duration, including medication-assisted treatment, and the continuation of laws that inhibit treatment and recovery services.

Many see the implementation of peer support services and recovery coaching as viable alternatives to more expensive specialty addiction treatment. The challenge is to ensure that decision makers are aware of and support a continuum of care which is holistic and accessible to individuals with substance use disorders, spanning from use to dependency and addiction. To be effective across this spectrum of disorders, services must be supported and include education, assessment, early intervention, treatment, and long-term recovery supports across the life span of individuals to produce a community focused on health and well-being for all who reside there.

Lack of Understanding and Support

Policymakers are still learning the importance of recovery-oriented systems of care and the process of recovery. The concept of addiction as a brain disease is still not fully understood and many still view addiction as a moral issue or personality/character defect. The stigma related to addiction remains high and policies to support addiction recovery are often slow to change. Media coverage often focuses on high profile cases of addiction, as opposed to the more mundane but affirming stories of people in successful recovery, creating a skewed perception.

More awareness and education is important to the success of recovery-oriented practices, at the political and public policy levels. While it appears that more legislators understand that addiction has its roots in physiology, the multiple demands in diverse areas of concern that they are called to address, often makes it difficult to reconcile support for addiction treatment and long-term recovery supports.

Challenges within the Criminal Justice System

People in recovery that are (re)entering the community from criminal justice institutions face a number of barriers. There are discriminatory policies that prevent people with criminal histories who in recovery from obtaining housing and employment. These are two key instrumental supports that are vital to recovery stabilization. In many states, landlords have legal right to not rent to persons with a history of incarceration (The Legal Action Center, 2004). Many states also allow prospective employers to include questions about past histories of felony convictions on applications for employment. This policy keeps many people in the recovery community from being able to access employment and legally support themselves.

Yet another barrier in many states concerns licensing. Licensing restrictions for people who have been formerly incarcerated can run the gamut from driver's licenses (making it difficult to access transportation to jobs) to a range of professional and vocational licenses. These restrictions make gainful employment, connections to the community, and long-term recovery more difficult.

Some states, such as Oregon and Florida, have recently passed legislation that prevents people with criminal pasts from working with "vulnerable populations." These new laws have a direct effect on people in recovery with criminal pasts who have been working in the addiction profession for years or even decades. Many are finding their jobs as counselors and case managers in peril, because the individuals and families with whom they are working meet the definition of "vulnerable populations" as defined in those laws. (The Legal Action Center, 2004).

Many people who have substance use disorders leave systems of incarceration after serving their time, only to return to families and communities that are not conducive to supporting recovery. Returning to an environment in which there is substance use and active addiction, may put them at risk of relapse. Alternately, peer and other recovery support services have proven to be helpful in reinforcing recovery and creating a recovery-supportive environment. Places like recovery community centers and services like those provided by peer recovery coaches can help both

individuals and families maintain substance and crime free lives, while offering volunteer and community engagement opportunities (The Legal Action Center, 2004).

Need for Emphasis on Prevention and Early Intervention

Historically, the addiction profession has largely focused on treatment services. However, shifting to a recovery-oriented system of care calls for services across the care continuum and includes treatment as well as prevention and early intervention services. However, individuals in need of addiction-related services are not routinely screened for substance use problems and early intervention services are lacking. Efforts are expanding to implement SBIRT programs (screening, brief intervention, and referral to treatment) but this expansion is not universal at this time. Thirteen states report that they are implementing the SBIRT model, and SAMHSA funds a competitive SBIRT grant that provides funding for adults in primary care and community health settings (Harwood, 2012). Further, some addiction prevention specialists report that they do not consider their role as a part of “recovery.”

Social Strengths

Upon reviewing the literature and speaking to key informants within the addiction profession, many social strengths for implementing a recovery-oriented model of care were identified.

Early Adopter of Recovery Concepts

As noted earlier in this document, the addiction profession was an early adopter of recovery concepts. As one addiction professional stated, “Everything starts with attitude and perception of the person in recovery. Implementing recovery-oriented concepts in the addiction profession is easier than in other professions. In this profession, there is at least an understanding of the recovery process.” Because most, if not all, early addiction professionals were in recovery themselves, recovery has historically been rooted in addiction practices.

Further, the addiction profession has been at the forefront of understanding recovery and recovery components, as evidenced by the competencies, skills, and attitudes that were created for addiction counselors. Later, these very attitudes, skills and competencies became the foundation for the skills identified in the *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice Technical Assistance Publication (TAP) Series 21* by SAMHSA, *Competencies for Substance Abuse Treatment Clinical Supervisors Technical Assistance Publication (TAP) Series 21-A* by SAMHSA and the *Performance Assessment Rubrics for the Addiction Counseling Competencies* by Northwest Frontier Addiction Technology Transfer Center (ATTC).

Culture of Mutual Support Groups

The history of mutual support groups is filled with activities and supports that are recovery-oriented. Since its inception, the addiction profession has encouraged the use of mutual support groups and peers to reinforce recovery. Back in the 1940s and 1950s, Alcoholics Anonymous (AA) mutual support groups were the most viable option for individuals prior to the development of the modern treatment systems. There are, however, many paths to recovery that include other

types of mutual support groups, including church/faith centered, non-spiritual support groups, and non-traditional support groups (White, 1998), which are widely used by those in short and long-term recovery.

Established Education Dissemination System

There are many established channels of education dissemination that exist within the addiction profession. NAADAC's breadth of reach to addiction and other helping professionals through face-to-face, online and home study courses, webinars, and manualized curricula is wide. Beyond its large membership base, NAADAC's distribution system includes its 46 state affiliates (which have their own board of directors), state and regional annual conferences, and other training events. Some states conduct their own training events or schools in conjunction with other partners, many of which include NAADAC's state affiliates. This partnering approach is healthy in expanding the breadth and depth of the conference, the reach in each geographic area, and the types/professions of persons involved. Additionally, the Addiction Technology Transfer Centers (ATTCs) were created and funded to help educate and build the addiction workforce and have developed an enormous amount of original educational resources.

Between NAADAC and the ATTCs, the potential for system-wide and nation-wide dissemination of RM/ROSC training, documents, and systems improvement as well as technical assistance is great. Further, the RTP Initiative will give rise to other collaborative opportunities to build effective systems of dissemination and adoption.

Along with these dissemination efforts, NAADAC would encourage meetings with NIDA's CTN Network to ensure the inclusion of research data related to the effects of RM/ROSC initiatives on short- and long-term clinical/recovery outcomes.

Social Barriers

There are many pervasive social barriers encumbering the process of building recovery-oriented systems of care. These barriers were articulated by consumers, addiction professionals and the NAADAC RTP Advisory Board.

Resistant Workforce

Even the most skilled addiction counselors are not immune to the challenges of change. Some members of the addiction profession hold specific belief systems and biases and lack flexibility to alter practices, incorporate new concepts and change comfortable patterns (e.g., *"See the whole concept as a sort of burden, and somehow to be encroaching on something they control"*; *"Fear of change"*; *"Change is difficult"*; *"Tough to move from I am the expert"*). Some of who hold these beliefs includes administrators who set and enforce policies for their agencies, as well as frontline clinicians.

In an interview with William White (2012), he notes the following as some of the social barriers for the uptake of recovery principles and practices within the addiction profession:

- Fear that RM/ROSC, with their emphasis on mobilization of community-based recovery support resources and peer-based recovery support services represent a de-professionalization of addiction treatment and a loss of status for addiction counseling.
- Fear that *“recovery-oriented systems transformation is putting lipstick on a pig—politically rationalizing cuts in professionally directed addiction treatment.”*
- Fear that *“these services are going to drive clients away from the ‘treatment professionals.’”*
- Defensiveness: *“Are you saying that all we have done in the past in addiction treatment is wrong?”* Resentment that the pathology-focused knowledge base that counselors have worked so hard to acquire is now being discounted.
- Beliefs that there is not a need for change: *“We’re already recovery-oriented”*; *“We tried that and it didn’t work”*; *“This recovery stuff is just another flavor of the month that will pass.”*

Some addiction professionals are resistant to expanding beyond 12-step philosophy and hold securely to the historical view of recovery within this structure. Many addiction professionals maintain that there is only one path to recovery and it requires complete abstinence from drugs and alcohol. “Harm reduction” is not seen by many in the addiction profession as a viable step to long-term recovery. There are myths and biases in the use of harm reduction and what those methods entail. NAADAC believes there is more than one path to treatment and recovery.

Some addiction professionals are resistant to the medicalization of addiction treatment. Not everyone has accepted the disease model of addiction and agrees that it is a chronic disorder that requires ongoing supports and many nonclinical services. Some believe the acute model of admit/treat/discharge is sufficient. In addition, even though there has been substantial uptake of medication-assisted treatment, some addiction professionals are still resistant to its use and hesitant to include those who receive it in some 12-step programs.

Some addiction professionals are resistant to adopting any practices that are perceived as more work. Addiction professionals are overworked, underpaid, and aging. They manage very heavy caseloads with burdensome documentation requirements (e.g., *“It is too time consuming to provide the different services”*; *“It ultimately means more work”*). As a result, they are short on time and struggle to provide enough individual attention to clients, coordinate between programs and providers, and arrange ancillary recovery-oriented services.

Concerns about a Peer Recovery Support Workforce

Although significant strides have been made to change the hearts and minds, some addiction professionals are resistant to working together and building a coalition with the organized recovery community. Specifically, some members of the clinical addiction treatment team have found themselves engaged in a “turf war” with peer recovery support workers. As a result, addiction recovery services are fragmented and uncoordinated. Without knowledge that a ROSC

model supposes that treatment is one component in a larger paradigm of recovery, some fear that “recovery will supersede treatment.”

Some addiction professionals have reservations about embracing peer recovery support workers because these positions are relatively new additions to the addiction workforce. It is believed that peer recovery support workers do not have identified scopes of practice or career ladder, which makes some members of the workforce feel “anxious” and “threatened” that they may lose their jobs. Perceptions about the lack of roles and responsibilities of this new sect of the addiction workforce have made some professionals concerned about the security of their jobs and the creation of “mini-counselors.”

Some addiction professionals are concerned about the competency of peer recovery support specialists since there are no established universal requirements of education, training, certification/licensure, or clinical supervision for these positions. Further, there are no well-established standards of care or a professional code of ethics that would outline clear boundaries, limitations of confidentiality, length of “sober time,” and accountability.

Inadequate Education and Training

Even though most addiction professionals understand and agree with the definition of recovery and its guiding principles, some are still struggling to develop a full conceptualization of recovery-oriented systems of care. Most, if not all, members of the addiction profession, including addiction counselors, peer recovery support specialists, clinical supervisors, administration, and medical personnel are under-educated on recovery-oriented concepts, skills, and practices. Beyond this, clients, families, communities, and the public-at-large are not well informed about recovery-oriented concepts.

Many members of the addiction profession are specifically lacking in education related to the benefits and implementation of recovery-oriented systems of care, benefits of collaboration, trauma-informed care, cultural competency, and co-occurring disorders.

Stigma

Public opinion of addiction and recovery is grounded in centuries of history, and a stigma against those in recovery still exists. It is sometimes perceived that recovery support services are “handouts” for those “trying to take advantage,” and those in recovery often experience employment discrimination for their recovery status. The attitude of “Not In My Back Yard” (NIMBY) is still alive and well in American culture. These attitudes intensify in a climate of economic and cultural strain, creating barriers to establishing or relocating treatment centers, recovery homes, recovery schools and ROSC centers (White, 2009; White, Evans, & Lamb, 2009).

The addiction profession also suffers from a self-imposed stigma that professionals not in recovery cannot fully understand the recovery process. Some addiction professionals call for the hiring of

more individuals in recovery to provide other nonclinical recovery services that are gained through the experience of being in recovery themselves.

There has been a backlash against 12-step programs modeled after Alcoholics Anonymous (AA) due to its perceived inseparable affiliation with Christianity. Therefore, a stigma has resulted against mutual support groups that they are exclusive and non-secular, even though many mutual support groups are designed to be inclusive and secular.

Lack of Resources

More addiction recovery services are needed, as addiction treatment slots are usually full and services are not always available within rural communities or for indigent/low-income or adolescent populations. Further, treatment slots need to be used more effectively and efficiently. Current treatment professionals are “locked into” patterns of treatment implementation that have been used for many years.

Addiction professionals struggle to maintain an accurate and relevant list of referral resources. Further, addiction professionals are receiving less face-to-face training (due to lack of funding and availability of unbillable work hours) and therefore have less time to network with colleagues and service providers and build meaningful relationships.

Technological Strengths

There is enormous potential for mobilizing new communication technologies for recovery support within the addiction profession. While computer technology was once beyond the reach of many addiction professionals and organizations, use and availability has increased significantly (Fox & Jones, 2009). As a result, new technological possibilities are on the horizon:

- Most addiction professionals use technology while performing their professional duties, such as accessing the Internet and frequently using emails systems to communicate with clients, colleagues, and referral sources. Some organizations use database software to track patient progress and medical software for case management (O*NET OnLine, 2010).
- Wide use of the Internet has enabled more individuals to access recovery-oriented education and literature through resource clearinghouses, webinars, online courses, e-zines, e-newsletters, daily email messages, e-books, and online talk radio programs. It has also spawned a new breed of online recovery communities, chat rooms, social networking communities, and mobile applications designed to support those in recovery.
- There is an expansion of addiction treatment services to underserved patients, providing more opportunities for patients to receive ongoing therapy through website portals and smartphone applications, and telephone/text recovery supports. Soon, patients in some remote areas may receive real-time video counseling on a routine basis via their computers, tablets (e.g., iPads), and smartphones. Therapists may receive feedback from their patients and monitor their medical progress through Web portals (Hyde, 2012).

- Interoperable electronic health record (EHR) systems may provide patients with information that allows shared decision-making with their clinician, home monitoring of patient-reported chronic health systems, and collaborating with other professionals to coordinate holistic care for the person in recovery. Consumers may be able to select a physician, treatment facility, and hospital based on clinical performance results (Hyde, 2012).
- In carrying out its Health Information Technology (HIT) Initiative, SAMHSA has launched a number of activities to assist behavioral health providers in adopting HIT and EHRs. One such project funded by SAMHSA is the Open Behavioral Health Information Technology Architecture (OBHITA). This is an open source software platform that is built on common standards to facilitate effective sharing of information between behavioral health (and addiction) providers and primary care systems providers while protecting the rights of the patient (Cogan, 2012).

Technological Barriers

Although technology shows great promise to improve the services of the addiction profession, not everyone is online yet:

- Fewer than half of behavioral health and human service providers possess fully implemented clinical electronic records systems (Centerstone Research Institute, 2009).
- Many behavioral health providers, as well as consumers and their families, have real concerns about how EHR systems and real time access to sensitive medical information can be achieved while fully protecting confidentiality. Providers and consumers want to know how to use promising new technologies securely while simultaneously safeguarding the privacy of EHR information (Cogan, 2012).

Recovery and the Addiction Profession

Historically, addiction professionals interpreted recovery from their own experiences and lacked a unified recovery orientation, making it difficult for uniform and mass implementation across professionals (Else, 1999; Morgan, 1995; Zweben, 1986; 1997; White, 2002). However, the profession has experienced significant shifts in the past several years that enhanced understanding and implementation of recovery values, concepts, and principles of addiction recovery (Kelly & White, 2011; White, 2008; 2009; 2011). There have also been efforts to define how addiction professionals could perform certain recovery-focused practices, such as recovery planning (Borkman, 1998), assertive linkage to communities of recovery (White, Kurtz, & Sanders, 2006), and perform recovery check-ups (Dennis & Scott, 2012). However, these have not been widely disseminated, and there has not been a systematic effort to translate principles of recovery to key practices of addiction professionals.

As a result, most professionals are becoming aware of broader changes required of addiction treatment (and the programs in which they work) but are not clear on precisely how they should change what they do on a daily basis to achieve this greater recovery orientation or what specific changes they should be encouraging within their programs.

Definition and Understanding of Recovery

Based on inquiries conducted by NAADAC, members of the addiction profession appear to be very knowledgeable about the concept of addiction recovery. Further, there is overwhelming agreement among addiction professionals of the core components of SAMHSA's definition of recovery. Most agree that recovery contains these four main concepts:

- A process of change
- Improving health and wellness
- Self-directed life
- Reaching full potential

When asked to formulate their own definition of recovery, some addiction professionals included the following additional concepts:

- Abstinence from drugs and alcohol
- Counseling, education, and skill-building
- Empowerment
- Evidence-based practices

- Extends beyond initial treatment for a substance use disorder
- Includes all aspects of the individual (spiritual, mental, behavioral, and physical)
- Includes family members (when appropriate and available), community, and other support systems
- Long-term and life-long
- Must be sustained and maintained
- Treatment is not required

These additions further demonstrate the stronghold of recovery concepts within addiction professionals, as many of these suggested additions are identified as guiding principles of recovery according to SAMHSA (2011).

Further, SAMHSA’s ten guiding principles of recovery (2011) are imbedded in the definition of recovery for most addiction professionals. An overwhelming majority of respondents to a NAADAC inquiry reported that each of the guiding principles were a part of their definitions of recovery.

The total number of responses from the inquiries was 164 persons.

Guiding Principle of Recovery	Percentage
a) Recovery emerges from hope	85.7%
b) Recovery is person-driven	86.7%
c) Recovery occurs via many pathways	91.8%
d) Recovery is holistic	90.8%
e) Recovery is supported by peers and allies	89.3%
f) Recovery is supported through relationship and social networks	90.3%
g) Recovery is culturally based and influenced	83.7%
h) Recovery is supported by addressing trauma	84.2%
i) Recovery involves individual, family and community strengths and responsibility	92.3%
j) Recovery is based on respect	86.7%

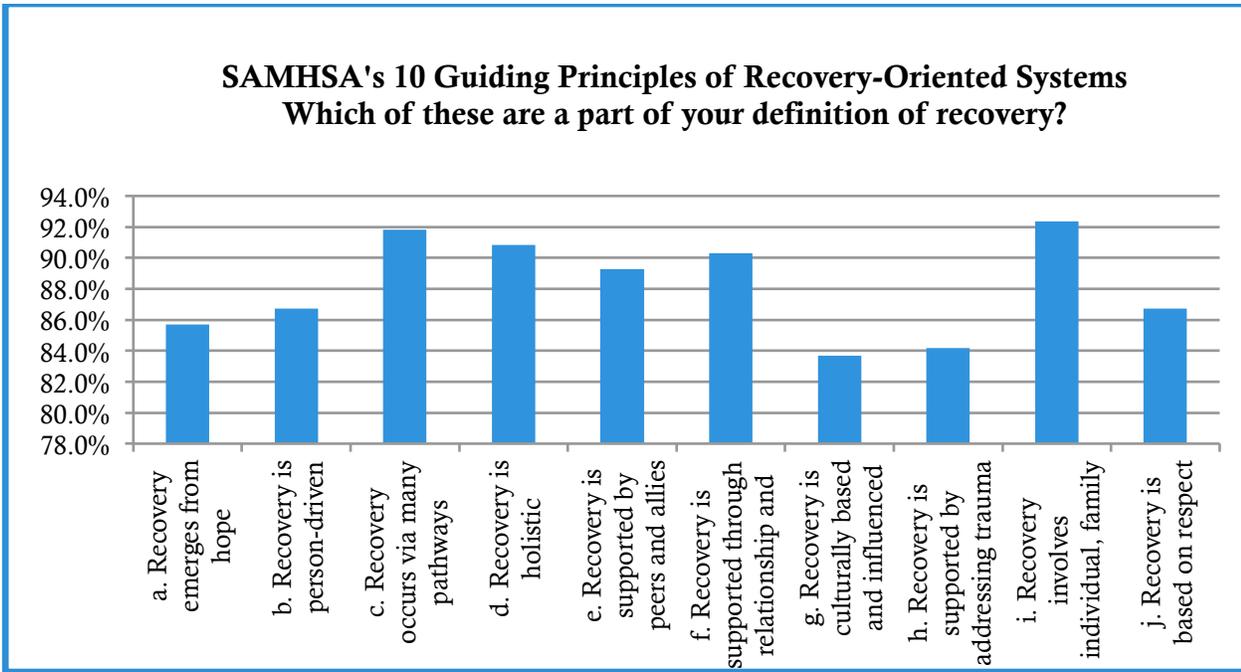
As illustrated by the chart below, these guiding principles have the strongest acceptance and understanding among members of the addiction profession:

- *Recovery involves individual, family and community strengths and responsibility*
- *Recovery occurs via many pathways*
- *Recovery is holistic*

- *Recovery is supported through relationship and social networks*
- *Recovery is supported by peers and allies*

These guiding principles showed a lower level of acceptance and understanding among members of the addiction profession and provide opportunities for further training:

- *Recovery is culturally based and influenced*
- *Recovery is supported by addressing trauma*
- *Recovery emerges from hope*
- *Recovery is based on respect*
- *Recovery is person-driven*



Based on self-reports from addiction professionals, recovery-oriented practices are partially built upon their personal and professional knowledge and practices. Some of these experiences include:

- Personal history of recovery and/or with significant others
- Professional experience with addiction, child welfare, criminal justice system, schools, and mental health
- Involvement in mutual support groups
- Continuing education from individuals and organizations

- Formal education at academic institutions
- Exposure to changes made at an organizational level to better integrate recovery concepts

Origination of recovery-oriented practices among addiction professionals has also been documented in the research. Some of the influencing factors include:

- Professional experience with proven limitations of acute care models of addiction treatment (e.g., problems of inadequate attraction, delayed access, weak engagement and early retention; inadequate emphasis on the value of client choice; weak linkage to indigenous recovery support resources in the community) (White, 2008).
- Exposure to theoretical constructs that are garnering increasing scientific support (e.g., wounded healer, helper principle, experiential knowledge, chronic illness/recovery management; cultures of addiction/treatment/recovery; recovery capital, recovery carrier, and community recovery) (White, 2009).
- Exposure to scientific support for key service practices (e.g., pre-recovery identification, engagement and recovery priming; recovery optimal treatment duration, personally matched combinations and sequences of professional treatment services and peer-based recovery support services; assertive linkage to communities of recovery; post-treatment recovery checkups, support and early re-intervention) (White, 2008).

Response of the Profession

Overall, based on direct feedback from addiction professionals, the response of the addiction profession to the concept of recovery is “positive,” and “good,” and addiction professionals are “eager to learn and implement recovery concepts” and “embrace the idea when they learn of it.” Further, “younger individuals and non-addicts” appear to be “quick to see the advantages of ROSC and have adopted it enthusiastically.” Further, members of the addiction profession are modeling the principles in their practice and living the principles of recovery in their own lives.

Many addiction professionals feel the concept of recovery is so embedded in their underlying philosophy and practice that they are one and the same. The following comment sums up the sentiment of this sect of the profession:

“Every piece of program development from the ground up and all aspects of serving consumers incorporates the principles...the principles ARE my model, rather than me 'using' the principles.”

However, many addiction professionals hold reservations about recovery-oriented concepts and principles. Some professionals report that this apprehension is due to the following:

- Threats to professional position
- Resistance to change

- Not abstinence-based
- Feeling devalued
- Lack of understanding and education
- Ethical concerns
- Lack of funding
- Fear of more work

Additional concerns are further outlined in the “Contextual Conditions for the Addiction Profession” section of this Situational Analysis.

Use of Recovery Concepts, Skills, Knowledge and Practices

In general, members of the addiction profession report that they are using recovery concepts and principles in their practice. An overwhelming majority of respondents to a NAADAC inquiry reported that each of SAMHSA’s guiding principles were a part of their practice.

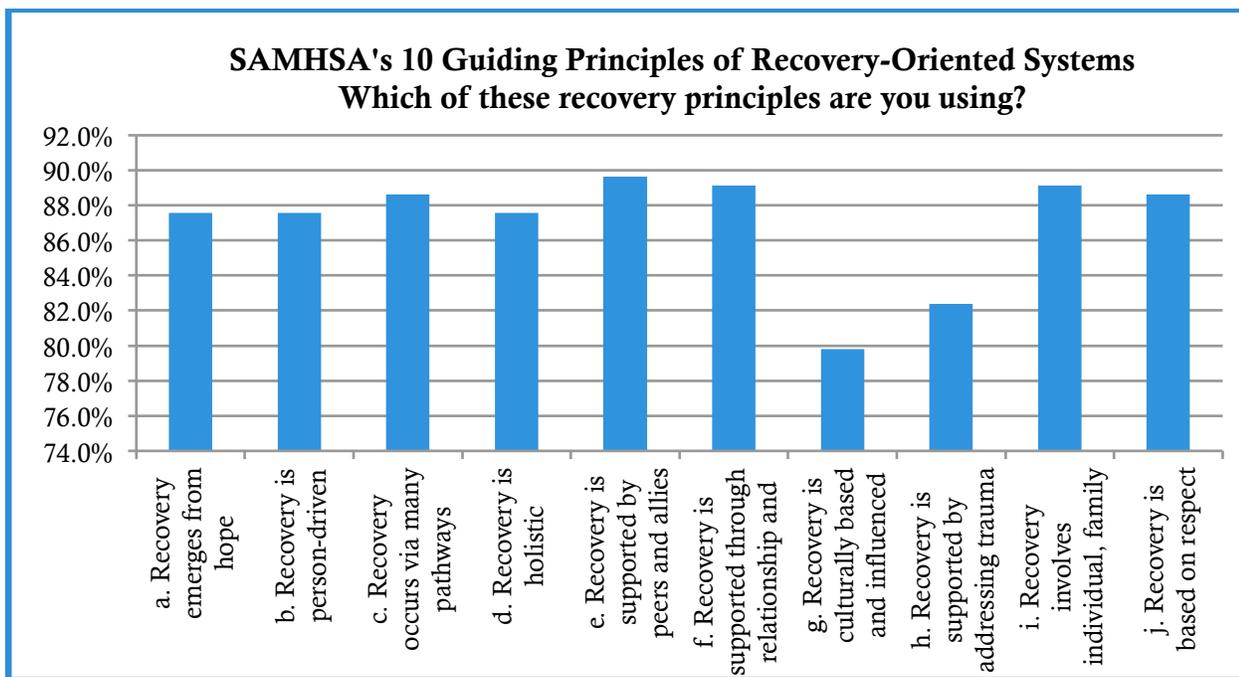
Guiding Principle of Recovery	Percentage
a) Recovery emerges from hope	87.6%
b) Recovery is person-driven	87.6%
c) Recovery occurs via many pathways	88.6%
d) Recovery is holistic	87.6%
e) Recovery is supported by peers and allies	89.6%
f) Recovery is supported through relationship and social networks	89.1%
g) Recovery is culturally based and influenced	79.8%
h) Recovery is supported by addressing trauma	82.4%
i) Recovery involves individual, family and community strengths and responsibility	89.1%
j) Recovery is based on respect	88.6%

As illustrated by the chart below, these guiding principles are being practiced the most:

- *Recovery is supported by peers and allies*
- *Recovery involves individual, family and community strengths and responsibility*
- *Recovery is supported through relationship and social networks*
- *Recovery is based on respect*
- *Recovery occurs via many pathways*
- *Recovery is person-driven*
- *Recovery emerges from hope*
- *Recovery is holistic*

Current practitioners need to improve their level of implementing the following recovery-oriented skills and knowledge into practice:

- *Recovery is supported by addressing trauma*
- *Recovery is culturally based and influenced*



Specifically, members of the addiction profession are utilizing recovery concepts, skills, knowledge, and practices in the following ways:

- *Recovery is supported by peers and allies:* encouraging mutual support groups; development of local Recovery Community Centers with peer and professional supports; fostering discussions and support to peers through group therapy; state-wide network of peer-to-peer prevention, treatment, and recovery services and supports; recovery coaching
- *Recovery involves individual, family and community strengths and responsibility:* engaging the consumer and his/her family; family support groups that focus on the family members' recovery; connections with community and peer supports; family education and orientation groups; family programs; work with churches/religious institutions; community member recruitment
- *Recovery is supported through relationship and social networks:* relationship oriented; mutual support groups; alumni networks, programs, meetings, and services
- *Recovery is based on respect:* utilizing/practicing MI/MET; treating all consumers with dignity and respect in all interactions; modeling respectful behavior; calling-out disrespectful attitudes and behaviors; staying within scope of practice

- *Recovery occurs via many pathways:* providing a menu of treatment services; collaborative process of determining treatment choices; sharing of success stories to expose clients to options
- *Recovery is person-driven:* individualized treatment/recovery plans that address specific needs of the client; let the client “drive the bus”; encouraged to believe that they have their own answers; use of the Stages of Change model to meet clients where they are; match services to their recovery preferences and needs whenever possible
- *Recovery emerges from hope:* system where peers share successes to encourage hope; everyone has the ability to live a purposeful life; encouraging hope in clients; expressing hope for clients; women’s empowerment groups; encouraged to believe in self; family supports to share hope and encourage a belief in self and the ability for change; providers model wellness and hope; alumni and peers sharing stories and experiences
- *Recovery is holistic:* emphasizing the “whole person”; holistic approach to treatment; bio-psycho-social-spiritual model used widely; emphasize total wellness and integration with physical health
- *Recovery is supported by addressing trauma:* staff knowledgeable of trauma informed care; hiring trauma-informed staff; trauma groups; making appropriate referrals
- *Recovery is culturally based and influenced:* being sensitive to cultural differences; respecting those differences and acknowledging the similarities; women’s empowerment groups; LGBTQ groups; accommodating religious and cultural dietary needs while in treatment; knowing where to refer clients for specific gender, culture, and psychological issues; allowances are made for spiritual diversity; diversity among staff; providing/seeking diversity-related education to have competent staff

In addition, members of the addiction profession are providing recovery-related prevention services by:

- Conducting early screening before onset through the SBIRT protocol;
- Collaborating with other systems, e.g., child welfare, Veteran’s Affairs, criminal and juvenile justice, public health, education, primary health care, legislative, judicial, and law enforcement partners, and faith-based community groups;
- Engaging in stigma reduction activities, such as advocacy efforts highlighting the accomplishments and positive attributes of recovering people and teaching at colleges/universities to emerging addiction professionals; and
- Referring clients to intervention treatment services.

Early intervention services by addiction professionals include screening for substance use disorders and brief intervention using the SBIRT protocol, overdose prevention groups, pre-treatment support services, court services, and community outreach.

Addiction professionals incorporate recovery concepts, skills, knowledge, and practices into treatment by offering:

- *A menu of treatment services:* evidence-based practices and treatments; eating disorder groups; relapse prevention groups; medication-assisted treatment options and education; co-occurring disorder groups; trauma informed groups and education
- *Recovery support services:* hiring peer recovery support specialists; offering Recovery Coaching programs; encouraging mutual support groups; working in multi-disciplinary treatment teams; therapeutic communities; case management
- *Additional services and therapies:* access to medical doctors, psychiatrists, nurses, nutritionists, exercise instructors, activities therapy, yoga, meditation, massage, acupuncture, art therapy, culturally specific traditions, rituals and customs, music therapy, and equine therapy
- *Prevention and treatment for families and siblings of individuals in treatment:* Al-Anon; directing family members to counseling; family groups; partnership counseling; CRAFT and other family based EBPs; Family Week programs
- *Clinical supervision:* ongoing feedback, guidance, training, and mentoring from peers and supervisors
- *Education:* ongoing education for themselves, staff, clients, and family

Post-treatment recovery-related services offered by addiction professionals include:

- *Continuing care:* alumni support groups; annual alumni reunions; viewing as “continuum of care”; referrals to various professionals based on individual need and collaborative care for each client as needed; providing referrals to community services after treatment
- *Recovery support services:* maintaining a wide range of active referral sources; encouraging mutual support groups; coordinating services with medical professionals, vocational, and rehabilitation services; childcare; coordination with educational organizations, mental health providers, probation officers, etc.; ongoing education; advocacy to courts and licensing boards for clients; faith-based support; recovery housing; transportation assistance; sober leisure skills
- *Check-ups:* case management; long-term outreach to continue with a focus on connectedness with peers; follow-up with clients to encourage their continued involvement with others in recovery and in their community

Addiction professionals report experiencing many personal and professional benefits as a result of adopting recovery-based practices. Some of these identified by addiction professionals include:

- Greater professional satisfaction and therapeutic optimism by seeing linkage between short-term stabilization and long-term addiction recovery. Addiction professionals report seeing living proof of the value of treatment through increased exposure to people in long-term recovery (e.g., longer contact with clients, greater contact with volunteers in recovery, greater contact with local communities of recovery).
- Satisfaction from broadened community partnerships, such as recovery community organizations, recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes, and recovery sports associations.
- Greater freedom to acknowledge their own personal/family recovery status, as therapeutically indicated (e.g., brief, strategic, well-timed).
- Discovery of the value of counseling for people in later stages of recovery.

Education and Training

In general, there is a moderate amount of education and training available about addiction recovery topics and recovery-oriented practices, but it is not widely disseminated. It appears that even though education and training resources are available and addiction professionals overwhelmingly report they would take advantage of recovery-oriented training, they are not accessing these resources at high rates.

Recovery education and training resources vary by state. Some states, such as Connecticut, New York, and Pennsylvania, have developed significant training resources around recovery concepts, but many states are deficient in this area. Significantly more training is needed across the country, especially in the areas of general education on recovery-oriented systems of care, cultural competency, and trauma.

Beyond individual states, current addiction education and training focus as a whole lacks several essential recovery dimensions (White, 2012):

Present Education/Training Focus	Missing Recovery Dimensions
Addiction (pathology) definition with defining elements and measurement tools	Addiction recovery (resilience, recovery, resistance) definitions and measurement tools, e.g., lack of DSM, ASI counterparts for recovery

Present Education/Training Focus	Missing Recovery Dimensions
Pharmacology of drugs/neurobiology of addiction/medical aspects of addiction	Neurobiology of addiction recovery/medical aspects of recovery (norms related to sleep, energy, appetite, cognitive functioning, sexual functioning, improvement/alleviation of addiction-related health problems)
History of drug use/addiction; Limited history of addiction treatment	History of addiction recovery, including new recovery advocacy movement, growth of grassroots recovery community organizations and other new recovery support institutions
Prevalence and patterns of substance use drawn from clinical populations	Recovery prevalence and patterns drawn from community and clinical populations
Theories of addiction and theories of counseling	Few comparable theories of recovery
Current emphasis on treatment as a process of incremental change (e.g., stages of change and use of MI to enhance recovery initiation and assertion of addiction as a chronic relapsing disorder)	Potential for transformative change that is sudden, unplanned, positive, and permanent
Techniques of individual, group and family counseling that focus on enhancing self-knowledge, self-development, self-assertion, self-control, self-confidence, self-esteem (“treatment as a process of getting into oneself”)	Recovery-focused reconstruction of identity, character, relationships, and resiliency marked by spiritual self-transcendence, mutual dependence, humility, tolerance, respect and service to others (“recovery as a process of getting out of oneself”)
Etiology and stages of substance use disorders (pathways of problem entry)	Pathways, processes, styles, and stages of long-term addiction recovery (pathways of problem resolution)
Family (system, subsystems and individuals) adaptations to progression of addiction	Family (as system, subsystems and individuals) adaptations across stages of long-term recovery, including adaptations to what Brown & Lewis have depicted as the “trauma of recovery” (Brown & Lewis, 1999)
Assessment of problem severity/complexity	Assessment of personal, family, and community recovery capital (White & Cloud, 2008)
Professionally-directed treatment planning	Person-directed recovery planning (Borkman, 1998)
Limited education/training on cultures of addiction	Cultures of recovery (White W. , 1996)

Present Education/Training Focus	Missing Recovery Dimensions
Techniques to support acute bio-psycho-social-spiritual stabilization, e.g., crisis intervention, short-term counseling	Techniques to support long-term personal/family recovery with emphasis on recovery checkups--techniques for post-treatment monitoring, support and early re-intervention; emphasis on potential role addiction professional can play in later stages of personal/family recovery
Role of medications in treatment	Role (risks and benefits) of medication in recovery initiation and long-term recovery maintenance (White & Torres, 2010)
Influence of patient cultural affiliation and personal/historical trauma on counseling process	Cultural pathways of long-term recovery—across the life cycle
Skills in patient, professional, and community education on addiction and its treatment	Recovery-focused patient, professional, and community education
Legal and ethical issues in addiction counseling	Etiquette of working with diverse communities of recovery across equally diverse cultural contexts
Interagency collaboration	Collaboration with and assertive linkage procedures to recovery mutual aid organizations and rapidly expanding recovery community organizations
Review of short-term treatment outcomes	Review of long-term recovery outcomes
Role of personal characteristics in predicting short-term treatment outcomes	Role of community culture and community recovery capital in predicting long-term recovery outcomes
Frequent note of intergenerational transmission of AOD problems	No discussion of potential role of recovery in breaking such intergenerational cycles and parenting strategies for recovering parents that can reduce risks of AOD problems in their children (White & Chaney, Commentary--Resilience and recovery across the generations: A critical research agenda, 2012)

Training and Technical Assistance

There are countless online courses, webinars, CD-ROMs, training videos, face-to-face seminars, and written monographs on addiction recovery and recovery-oriented practices. Training topics delivered across these mediums include:

- Co-occurring disorders
- Conflict resolution

- Cultural competency
- Disease model of addiction
- Empowerment
- Evidence-based practices
- Family recovery
- Medication-assisted treatment
- Motivational Interviewing
- Peer recovery support services
- Prevention
- Recovery-oriented systems of care
- SBIRT
- Spirituality
- Stages of Change model
- Trauma
- Writing and recovery

For example:

- Southern Coast ATTC *Recovery Frameworks 2012* training curriculum
- Washburn University *Peer Mentor: Recovery-Oriented Systems of Care* 15-hour course
- Access to Recovery (ATR) *Recovery Coach Curriculum*
- The BIG Initiative (in partnership with NAADAC) *The EAP and Behavioral Health Professional's Guide to Screening, Brief Intervention and Treatment (SBIRT)* 6-hour online course, 7-episode webinar series, face-to-face seminars, and Training-of-Trainer program
- Hazelden *Integrated CBT for Co-occurring PTSD and Substance Use Disorders* online course
- Prairielands ATTC webinars: “Behavioral Health Webinar Series: Asian Americans and Pacific Islanders Substance Abuse Prevention & Treatment” and “Behavioral Health Webinar Series: Recovery Coaching”
- Connecticut Community for Addiction Recovery (CCAR) 5-day Recovery Coach Academy (RCA)
- NET Training Institute *Recovery Coach Program* 138-hour course
- Northeast ATTC “Improving the Quality and Outcomes of Buprenorphine Treatment” CD-ROM
- The McShin Foundation *Recovery Coach Manual*
- Office of National Drug Control Policy (ONDCP) “Supporting Recovery from Alcohol or Drug Addiction on Campus Recovery High Schools & Collegiate Recovery Programs” webinar

- Southeast ATTC and Great Lakes ATTC *ROSC (Recovery-Oriented Systems of Care): Life Beyond Treatment* (Four DVDs and CD-ROM of Resource Documents)
- White, W., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.
- White, W., Kurtz, E. & Sanders, M. (2006). *Recovery Management*. (Monograph) Chicago, IL: Great Lakes Addiction Technology Transfer Center.
- White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

All of the recovery-focused training and technical assistance programs mentioned above could serve as models for replication for various components of future training curriculums. In addition, NAADAC has a host of recovery-focused training products ready for mass dissemination:

- *New Innovations with Opioid Treatment: Buprenorphine* online course, manualized independent study course, face-to-face seminars, and Training-of-Trainer program
- *Motivational Interviewing: Clinical Practice with Pharmacotherapy* online course, manualized independent study course, face-to-face seminars, and Training-of-Trainer program
- *Medication Management for Addiction Professionals: Campral Series* online course, manualized independent study course, face-to-face seminars, and Training-of-Trainer program
- *Pharmacotherapy: Integrating New Tools into Practice* manualized independent study course, face-to-face seminars, and Training-of-Trainer program
- *Blending Solutions: Integrating Motivational Interviewing with Pharmacotherapy* online course
- *Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know* online course, manualized independent study course, face-to-face seminars, and Training-of-Trainer program (in partnership with Hazelden)
- *Conflict Resolution for Professionals and Clients in Recovery* manualized independent study course, face-to-face seminars, and Training-of-Trainer program
- Several archived webinars on conflict resolution, co-occurring disorders, medication-assisted treatment, cultural considerations, peer recovery supports, and evidence-based practices
- Planned webinars in 2012 on co-occurring disorders and medication-assisted treatment

Professional Conferences

NAADAC's conferences and meetings have historically highlighted recovery concepts and practices. In fact, NAADAC's 1988 annual conference was called "The Magic of Recovery" and focused on many of the recovery concepts outlined by SAMHSA. Today, NAADAC continues to educate addiction professionals about recovery-oriented practices through its conferences and meetings. For the past two years, approximately 40% of the keynote presentations and breakout sessions offered at NAADAC's annual conference (held in partnership with *Addiction Professional* and NALGAP, The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies) were related to recovery and recovery-oriented practices. This trend is scheduled to continue for NAADAC's 2012 "Leading the Way" Annual Conference. Previous session topics include:

- Alumni services and support
- Co-occurring disorders
- Cultural competency
- Family recovery
- Medication-assisted treatment
- Motivational Interviewing
- Peer recovery support services
- Prevention
- Recovery-oriented systems of care
- SBIRT
- Spirituality
- Stages of Change model
- Trauma
- Writing and recovery

Many other national conferences relevant to addiction professionals offer keynote presentations, breakout sessions, and poster presentations regarding recovery-related concepts. For example:

- American Society of Addiction Medicine (ASAM) – "Quality of Life Among Healthcare Professionals in Recovery"; "Leveraging Long-Term Recovery with Contingency Monitoring"; "Using Medications to Assist in Recovery from Opioid Dependence: The Role of Naltrexone"
- National Association of Addiction Treatment Providers (NAATP) Annual Addiction Treatment Leadership Conference – "Global Recovery Solutions"; "Implementing Integrated Treatment for Co-occurring Disorders"; "Abstinence versus Medicated-Assisted Recovery"
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)/National Prevention Network/National Treatment Network Annual Meeting – "Expanding and Improving Recovery Services"; "Key Initiatives in Prevention"
- State Associations of Addiction Services (SAAS) Annual Conference and NIATx Summit - "Massachusetts as a Model for Paying for Recovery Support Services in the Age of

Healthcare Reform”; “Lincoln County Outreach: Recovery Coaching”; “Comprehensive Recovery Services Center”; “Recovery in the Community: An Emerging Framework- A Recovery-Oriented Systems Approach”

Some professional organizations further promote recovery education by dedicating entire conferences, programs, days, and/or tracks to recovery and recovery-oriented practices. For example:

- Addiction Technology Transfer Centers (ATTCs) Regional Symposiums
- American Association for the Treatment of Opioid Dependence, Inc. (AATOD)
- International Certification & Reciprocity Consortium (IC&RC)
- Joint Meeting on Adolescent Treatment Effectiveness (JMATE)
- National Conference on Addiction Disorders (NCAD)
- National Council for Community Behavioral Healthcare

In addition, there are copious recovery-related presentations at local, state, and regional conferences that have occurred over the past several years.

Even though recovery-oriented content is present at most conferences for addiction professionals, there is room for improvement. Suggestions include encouraging the inclusion of:

- Presentations and poster sessions of recovery-focused topics and research;
- Presentations by frontline addiction professionals describing RM/ROSC systems transformation efforts within their treatment programs;
- Panels of persons in long-term recovery describing varieties of recovery experience and pathways, related recovery support structures, and best linkage procedures; and
- Networking opportunities to encourage discussion among participants.

Certificate Programs

NAADAC currently has two certificate programs that were developed to deepen the understanding and competency in a specific area of study related to recovery:

- Conflict Resolution in Recovery Certificate Program (which is trauma informed)
- Spiritual Caregiving to Help Addicted Persons and Families Certificate Program

NAADAC is currently in the process of developing five more certificate programs related to recovery:

- Recovery-oriented Practices and Services Certificate Program
- Clinical Supervision Certificate Program (with a component to address supervising peer recovery support specialists)
- Ethics Certificate Program (with components to address cultural competency, respect, and empowerment)
- Co-occurring Disorders Certificate Program
- Medication-assisted Treatment and Recovery Certificate Program

Colleges and Universities

In general, recovery-oriented concepts and practices are not widely integrated into academic institutional training curriculums. Upon review of colleges and universities among the National Addiction Studies Accreditation Commission (NASAC) and NAADAC's Approved Academic Education Providers, it was discovered that very few programs had course offerings or evidence of recovery-oriented concepts within their syllabi. Granted, most college and university programs for addiction professionals encourage follow-up with clients after discharge and teach courses on evidence-based practices and theories, but beyond this, most collegiate addiction studies programs remain lacking in specific recovery-focused education.

It appears that demand for recovery-focused education has outpaced the development of the textbooks and media to provide that training. Despite this, the following schools have implemented some recovery-oriented education:

- Washburn University offers two courses: *Peer Mentor: Recovery-Oriented Systems of Care* and *Addiction Services Coordination* (taught with a recovery orientation).
- The University of Arkansas at Pine Bluff Master of Science in Addiction Studies emphasizes both the prevention and treatment of addiction in their program.
- Rhode Island College has an academic specialization in co-occurring disorders.
- Elgin Community College offers a course on crisis intervention that includes trauma treatment.
- California State University Fullerton uses texts that teach about recovery-oriented concepts and hire faculty who support these practices.
- Brown University offers coursework on cultural competency and person centered recovery planning.
- University of South Dakota Division of Behavioral Health Addiction Studies reports imbedding recovery-orientation into all of their course offerings.

It was more commonly found that professors use recovery-oriented language in their teaching, such as “recovery-oriented treatment” instead of “treatment” and referring to counselors as “recovery-based addiction counselors.” One professor summarized the importance of this by saying, “*Little things like this I believe will start to make the shift. Then, of course, I have to explain what I mean by being recovery-based and then the discussion and change in perspective takes off!*”

In order for recovery-oriented concepts to be widespread and embedded in future generations of addiction professionals, educational institutions must increase exposure to this content. Suggestions for increasing recovery-oriented content and practices at educational institutions include:

- Conduct a systematic review of addictions studies curricula with recommendations on how recovery and recovery-based practices could be incorporated into key courses and internship experiences;
- Link organizational members of the Association of Recovery Community Organizations (RCOs) to local college/university-based addiction studies programs for educational exchanges (e.g., recovery panels in classes; visits to RCOs as part of internship or class assignments);
- Develop a recommended acquisitions list of recovery-focused books and journals for schools with addiction studies programs (e.g., disseminate ATTC RM/ROSC monographs and SAMHSA ROSC monographs to all addiction studies programs in the US); and
- Engage the International Coalition of Addiction Studies Educators (INCASE), NASAC, the Association of Recovery Schools, the Association for Recovery in Higher Education, and NAADAC’s Approved Academic Education Providers in discussions of recovery-focused curricula modifications and publish such recommendations in professional publications related to addiction.

Professional Publications

The addiction profession has numerous professional journals, magazines, and newsletters that offer in-depth information and analysis on fundamental issues, policy changes, new legislation, research findings, and business news to interested parties. Of the 57 professional publications identified as addiction-oriented, all have previously included information on recovery and recovery-oriented practices. (See Appendix B for a full list of addiction-related publications.) Two journals have the word “recovery” within their titles:

- *Journal of Ministry in Addiction and Recovery*
- *Journal of Groups in Addiction and Recovery*

All addiction-related professional journals and magazines published at least one or more articles pertaining to recovery and/or recovery-related practices, with a few publications producing several hundred. These addiction-related publications are the most prolific on the topic:

- *Addiction*
- *Addiction Professional*
- *Addictive Behaviors*
- *Alcoholism Treatment Quarterly*
- *Alcoholism and Drug Abuse Weekly*
- *Alcoholism: Clinical and Experimental Research*
- *American Journal of Drug and Alcohol Abuse*
- *Contemporary Drug Problems*
- *Counselor*
- *Drug and Alcohol Dependence*
- *Journal of Drug Issues*
- *Journal of Groups in Addiction and Recovery*
- *Journal of Ministry in Addiction and Recovery*
- *Journal of Psychoactive Drugs*
- *Journal of Social Work Practice in the Addictions*
- *Journal of Studies on Alcohol and Drugs*
- *Journal of Substance Abuse Treatment*
- *Journal of Substance Use*
- *Substance Use and Misuse*

Further, the *Journal of Substance Abuse Treatment* and the *Journal of Groups in Addiction and Recovery* have published Special Issues related to recovery and recovery-oriented practice.

Beyond this publications list, there are numerous electronic and printed newsletters produced by local, state, and national organizations and agencies containing recovery-related content. The various Addiction Technology Transfer Centers (ATTCs) and William White are also significant sources of original recovery-related literature.

Advances in Addiction and Recovery – the Official Journal of NAADAC, the Association for Addiction Professionals is currently in development. As the name implies, this publication will provide addiction professionals and members of the Association news articles, continuing education opportunities, and relevant updates that are focused on addiction, recovery, and recovery-oriented practices.

Because formal and frequent communication with the addiction profession is necessary to advance the recovery movement, further increasing recovery-oriented content in professional journals is essential. Suggestions for growth include:

- Increase NIAAA & NIDA portfolios of recovery research;
- Encourage special recovery-focused issues;
- Include more recovery-focused researchers on editorial advisory boards;
- Present on the emerging recovery paradigm to the International Society of Addiction Journal Editors; and

- Contract for translation of recovery-oriented research to clinical practice via articles in such professional trade journals as *Advances in Addiction and Recovery*, *Counselor*, *Student Assistance Journal*, and *EAP Digest*.

Certification and Licensure

Since its creation in 1990, the National Certification Commission for Addiction Professionals (NCC AP) has instituted nationally recognized credentials specifically for alcohol and drug field. The NCC AP operates as a distinct body from NAADAC, managing credentials and additional services, including test administration, certification fees, ethics, and rules of procedure. The NCC AP continues to develop national credentials in an effort to create a clearly validated and competent workforce.

Baseline credentials for the addiction profession, such as NCC AP's National Certified Addiction Counselor, Level I (NCAC I), National Certified Addiction Counselor, Level II (NCAC II), and Master Addiction Counselor (MAC), generally include elements of recovery but do not specifically mention or require recovery concepts. For example, these credentials emphasize evidence-based practices, respect, person-driven philosophy, and usage of mutual support groups but do not require education on each. Similar credentials offered by the International Certification & Reciprocity Consortium (IC&RC) and state licensing/credentialing boards lack the same specificity.

The development of the NCC AP's Recovery Coaching and Mentoring Credential (working title) is currently paused, as the research and validation of the competencies necessary for this distinction are not yet clear. NAADAC sits on the Faces and Voices of Recovery Accreditation Advisory Council. This system will be ready by late 2013 and will provide for national accreditation for qualifying recovery community and allied organizations that provide peer recovery support services. Once this work is completed, the NCC AP will resume its development after standards are set so that it has a framework for its final product that meets state and national requirements. Once NAADAC's Recovery Coaching and Mentoring Credential is finalized, five states have expressed interest in adopting these national standards as their own:

- Indiana
- Nevada
- New York
- Kansas
- New Mexico

International Certification & Reciprocity Consortium (IC&RC) offers five national recovery-oriented credentials:

- Prevention Specialist (PS)
- Certified Criminal Justice Addictions Professional (CCJP)
- Certified Co-Occurring Disorders Professional (CCDP)

- Certified Co-Occurring Disorders Professional Diplomat (CCDPD)
- Currently under development: Peer Recovery Coach (PRC)

These state addiction agencies also have credentials related to recovery:

- California – Registered Recovery Worker (RRW)
- Connecticut - Certified Co-Occurring Disorders Professional (CCDP); Specialty Certificate of Competency in Co-Occurring Disorders (SCCD); Medication Assisted Treatment Specialist (MATs); Certified Prevention Professional (CPP); Associate Prevention Professional (APP); Specialty Certificate of Competency in Problem Gambling (SCPG)
- Florida - Certified Recovery Peer Specialist - A (CRPS-A); Certified Recovery Peer Specialist - Family (CRPS-F); Certified Recovery Peer Specialist (CRPS)
- Georgia - Certified Addiction Recovery Empowerment Specialist (CARES)
- Illinois - Certified Criminal Justice Professional (CCJP); Certified Family Partnership Professional (CFPP); Board Registered Interventionist (BRI); Medication-Assisted Addiction Treatment Professional (MAATP); Certified Recovery Support Specialist (CRSS); Gender Competent Endorsement (GCE)
- Kansas - Kansas Certified Peer Mentors (KCPM)
- Michigan - Certified Prevention Specialist (CPS); Certified Prevention Consultant (CPC-R); Certified Criminal Justice Professional (CCJP); Certified Co-Occurring Disorders Professional (CCDP); Certified Co-Occurring Disorders Professional - Diplomat (CCDP-D)
- Missouri - Missouri Recovery Support Specialist (MRSS); Certified Criminal Justice Professional (CCJP); Certified Co-Occurring Disorders Professional (CCDP); Certified Co-Occurring Disorders Professional – Diplomat (CCDP-D)
- New Hampshire - Certified Recovery Support Specialist (CRSW); Certified Prevention Specialist (CPS)
- New Jersey - Certified Recovery Support Practitioner (CRSP)
- Pennsylvania - Certified Recovery Specialist (CRS); Certified Prevention Specialist (CPS); Certified Criminal Justice Addictions Professional (CCJP); Certified Case Manager (CCSM); Certified Case Manager Supervisor (CCMS); Certified Allied Addiction Practitioner (CAAP); Certified Co-Occurring Disorders Professional (CCDP); Certified Co-Occurring Disorders Professional Diplomat (CCDP Diplomat)
- Texas - Peer Recovery Support Specialist (PRSS)

Organizational Functions

Recovery appears to have a strong presence in the organizational infrastructure of addiction-focused organizations and agencies. Further, many organizations and state agencies are implementing reform initiatives that reflect recovery principles and practices. The following are a few organizations that are excelling in this area and could serve as models for recovery-focused system reform for the addiction profession:

- NAADAC, the Association for Addiction Professionals
- Connecticut Department of Mental Health and Addiction Services (DMHAS)
- Faces and Voices of Recovery
- Hazelden
- Rhode Island College Institute For Addiction Recovery
- WestBridge Community Services
- Willamette Family, Inc.

Many organizations have mission and vision statements that reflect recovery concepts. For example:

- NAADAC Vision Statement: *"NAADAC is the premier global organization of addiction focused professionals who enhance the health and recovery of individuals, families and communities."*
- Faces and Voices of Recovery Mission Statement: *"Faces & Voices of Recovery is dedicated to organizing and mobilizing the over 20 million Americans in recovery from addiction to alcohol and other drugs, our families, friends and allies into recovery community organizations and networks, to promote the right and resources to recover through advocacy, education and demonstrating the power and proof of long-term recovery."*
- Rhode Island College Institute For Addiction Recovery Vision Statement: *"We envision a cohesive community response to addiction which ensures that all Rhode Islanders have access to an effective and respectful recovery-oriented system of care."*
- Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) Mission and Vision Statement: *"Every individual served by the Mental Health and Substance Abuse Service system will have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family members and friends."*
- Indiana Division of Mental Health and Addiction (DMHA) Mission Statement: *"To ensure that Indiana citizens have access to quality mental health and addiction services that promote individual, family and community resiliency and recovery."*

- Hazelden Mission Statement: *“Hazelden helps restore hope, healing, and health to people affected by addiction to alcohol and other drugs.”*
- Valley HealthCare System Mission Statement: *“Valley HealthCare System shall improve our community’s health by delivering the highest quality behavioral health care guided by consumers’ needs.”*
- La Hacienda Treatment Center Mission Statement: *“We provide treatment and support to maximize recovery for each alcohol/drug dependent patient and his/her family.”*

For many organizations, recovery-oriented concepts and practices are imbedded within formal policies and procedures, guiding principles, core values, and promotional materials. For example:

- NAADAC tagline: *“We help people recover their lives.”*
- WestBridge Community Services description: *“WestBridge is a private, non-profit, organization dedicated to supporting the recovery of individuals that experience co-occurring mental illness and substance use.”*
- American Society of Addiction Medicine (ASAM): Adopted “Public Policy Statement on the State of Recovery” on February 1, 1982
- Hazelden promotional materials: *“The time spent at Hazelden is intended to provide a fresh start with support, education and therapy to aid in long-term recovery and a healthy, sober life.”*
- Connecticut Department of Mental Health and Addiction Services (DMHAS) “Commissioner's Policy Statement No. 83 - Promoting a Recovery-Oriented Service System”: *“The purpose of this policy is to formally designate the concept of ‘recovery’ as the overarching goal of the service system operated and funded by the Department of Mental Health and Addiction Services...”*
- Oregon Addictions and Mental Health Services recovery website: “Addiction and Mental Illness Recovery”
- New York State Office of Alcoholism and Substance Abuse Services recovery website: “Building a Foundation for Recovery In New York State”
- Hazelden value: *“Treat every person with dignity and respect.”*
- Heartland Regional Alcohol & Drug Assessment Center (RADAC) value: *“All individuals have worth and the innate ability to grow and change in order to achieve full potential; this responsibility lies within the individual.”*
- Pretera Center for Mental Health Services, Inc. use of alternative language: *“We no longer ‘discharge’ clients; rather, they transition to another level of care.”*

In addition, many organizations promote the understanding and use of recovery-oriented practices by providing onsite training for their staff and including recovery topics in annual staff development and strategic planning.

Recovery-oriented skills and practices are also making their way into formal job descriptions for addiction professionals. For example, The *Occupational Outlook Handbook* (Bureau of Labor Statistics, 2012) describes Substance Abuse and Behavioral Disorder Counselors as professionals who “*provide treatment and support to help the client recover from addiction or modify problem behaviors.*” Further, some organizations currently employ addiction professionals with the following job titles:

- Alumni Services Coordinator
- Continuing Care Coordinator
- Executive Director of Recovery Management
- Family Advocate
- Family Education Support Coordinator
- Peer Associate in Training
- Peer Coach
- Peer Recovery Mentor
- Peer Support Specialist
- Recovery Coach

The recovery movement is spreading beyond state addiction agencies and treatment providers, and organizations that are solely dedicated to addiction recovery are forming across the country. For example:

- Advocates for Recovery through Medicine (ARM-ME)
- Detroit Recovery Project
- National Association of Recovery Residences
- People Advocating Recovery
- Substance Abuse and Addiction Recovery Alliance
- Treatment Professionals in Alumni Services
- University of Texas Center for Students in Recovery
- Young People in Recovery

Implementation within States

Almost all state substance abuse agencies have made important strides in incorporating recovery-oriented conceptual elements into their systems of care. Almost all states have taken steps to implement a recovery-oriented system of care, and many states are already employing some

recovery-oriented services. However, only a few states are in the midst of comprehensive reform. Most states are still in the developmental stages of reform and working to change state policies and reforming billing processes to be more in-line with recovery-oriented services (Harwood, 2012).

In an inquiry conducted by NASADAD, seven states are disseminating training to provide a general understanding of recovery-oriented systems of care to state legislators, policymakers, and treatment providers. However, more training is needed; 17 states requested technical assistance and ten states requested training to advance their recovery-oriented system of care (Harwood, 2012).

Readiness Assessments

Many states have conducted a formal process to assess readiness to change or adopt new practices. According to inquiries conducted by NASADAD, about half to three-quarters of states have completed or are in the process of performing ROSC-related readiness assessments, needs assessments, defining conceptual elements, strategic planning, and implementation. Readiness assessments are also being conducted on the local level, including assessments among regional and county authorities, as well as directly with providers. Some entities report working closely with their ATTC to conduct these assessments (Harwood, 2012).

State Case Studies

Below is a summary of an in-depth look at the implementation efforts of Connecticut, Maryland, Michigan, and Philadelphia, which are in various stages of integrating recovery-oriented concepts. All of these local or state addiction organizations could serve as models of organizational structure and administration that support recovery-focus and consumer involvement.

Elements of Recovery-Oriented Systems of Care	CT	MD	MI*	Philly
Person-Centered	✓	✓	✓	✓
Family and Ally Involvement	✓	✓	Pledged	✓
Individualized and Comprehensive Services Across Life Span	✓	In process	Pledged	✓
Systems Anchored in the Community	✓	In process	Pledged	✓
Continuity of Care	✓	In process	Pledged	Enhancing
Partnership-Consultant Relationships	✓	In process	Pledged	✓
Strength-Based	✓	In process	Pledged	✓
Culturally Responsive	✓	✓	Pledged	✓

Responsiveness to Personal Belief Systems	✓	In process	Pledged	✓
Commitment to Peer Recovery Support Services	✓	Not yet in process	Pledged	✓
Inclusion of the voices and experiences of recovering individuals and their families	✓	✓	Pledged	✓
Integrated services	✓	✓	In process	✓
System-wide education and training	✓	✓	Pledged	✓
Ongoing monitoring and outreach	✓	✓	Pledged	✓
Outcomes Driven	✓	In process	Pledged	✓
Research Base	✓	✓	Pledged	✓
Adequately and Flexibly Financed	Continuous Process	Continuous Process	Pledged	Continuous Process
*Pledged as Part of MIs Implementation Plan				

Specific Areas of Focus

Culturally Competent Practice

Operationally defined, cultural competence is the awareness and incorporation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings, thereby facilitating positive outcomes (Davis & Donald, 1997). Included within this perspective is the recognition of culturally-specific pathways of recovery (including many pathways to recovery), the integration of culturally-specific healing practices within the context of addiction treatment, and the need to forge enduring partnerships between professional treatment organizations and culturally indigenous communities (Brady, 1995; Coyhis & White, 2002; 2006; Evans, Achara-Abrahams, Lamb, & White, in press; Spicer, 2001; Taylor, 1987). Culturally competent practice is essential to recovery-oriented models of care and must be highlighted in future training curricula.

NAADAC's Activity

For over two decades, NAADAC has focused energy and resources on promoting culturally competent practice within the addiction profession. Since the early 1990s, NAADAC has supported a variety of national committees, focused trainings, monographs, and magazine articles that have a mission to increase the understanding and knowledge of cultural, ethnic, social, age, and racial issues that will inform clinical and administrative policies and practices. NAADAC also supports cultural diversity training at our Annual Conferences and specifically recruits trainers from diverse ethnic, racial, religious, and social backgrounds to present sessions.

NAADAC created specific committees for “Native American,” “Hispanic,” “Black,” “Asian,” “Adolescent,” and “Gay, Bi-sexual, Lesbian, Transgender” populations that provided information, technical assistance, and training to NAADAC members and non-members alike. By the 2000s, NAADAC collapsed those committees into one committee that had as its main mission to encompass cultural competency issues within clinical issues, thereby creating the Clinical Affairs Committee.

NAADAC leadership and staff are involved in partnering and/or sitting on boards with other culturally and racially diverse organizations, such as: Historic Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), Behavioral Health Institute, National Asian Pacific American Families Against Substance Abuse (NAPAFASA), NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies, Latino Colleges and Universities (in development), and White Bison Native American Training Institute.

As an organization, there is still much work to be accomplished to develop a culturally diverse and competent workforce that reflects the demography of the populations that the addiction profession serves.

Necessity for Additional Training

Through the Situational Analysis, it was discovered that SAMHSA's guiding principle "Recovery is culturally based and influenced" is among the least utilized and accepted component of recovery. More education and training is needed to explain the importance of this guiding principle of recovery but also how to transfer this understanding into practice.

For example, it is essential for addiction professionals to understand that for many individuals within communities of color the individual, the family, and the community are inseparable. In working with Native American tribes in South and North Dakota and Eskimo tribes in Alaska, NAADAC was reminded that working with the individual person is not enough; it has to be working with the whole tribe: elders, leaders, young, and old. The whole community needs to be involved and afforded the opportunity to use their own traditions and rituals, words and language, stories, and examples. Also, for Asian populations, alternatives to 12-step mutual aid are vital and finding and incorporating support for these populations on a cultural level is necessary.

Future training curricula must include specific examples and practices relevant to the diverse clientele being served by addiction professionals.

Steps for Improvement

In a 2008 article written by William White and Mark Sanders entitled, *Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities*, the authors recommend that the addiction profession develop a broader vision of creating healthy cultures of recovery within communities by engaging in the following (White & Sanders, 2008):

- An ecological perspective on the etiology of alcohol and drug problems (to include historical trauma);
- A broadened target of intervention (including families, kinship networks, and communities);
- A proactive, hope-based model of service engagement;
- The inclusion of indigenous healers and institutions in service design and delivery;
- An expanded menu of culturally-grounded recovery support services;
- An extended time-frame of recovery support;
- A partnership-based service relationship; and
- A culturally-nuanced approach to research and evaluation.

Their suggestions can be applied beyond racially diverse populations and extended into all areas of cultural competence. Following such guidelines, NAADAC will develop training and

education that increases cultural competency and closes the gap of acceptance and utilization of culturally-based services by addiction professionals.

Role of Trauma and Trauma-Informed Care

Both historical trauma (Brave Heart & DeBruyn, 1998; Coyhis, 2008) and developmental trauma (Titus, Dennis, White, Scott, & Funk, 2003) can play a role in the onset, severity, and course of substance use disorders, as well as serve as mechanisms for the intergenerational transmission of substance use and related disorders (Brave Heart, 2003; Arria, Mericale, Meyers, & Winters, 2012). Recovery-oriented addiction treatment/counseling addresses trauma from multiple perspectives, including assuring safety and sanctuary within the treatment milieu, preventing the replication of victimization and abandonment within the service relationship, assuring continuity of contact in a primary recovery support relationship over time, integrating evidence-based practices in the treatment of trauma, and focusing on community recovery as well as individual and family recovery (White, 2008; White, Evans, & Lamb, 2010).

In the recovery-oriented systems of care approach, trauma-informed care is not a set aside or a standalone initiative that is addressed separately. It is an overall approach that is integrated into the treatment process (organizational) at the level of the individual, and the family and the community (systemic) as a whole.

Necessity for Additional Training

Through the inquiries and interviews conducted with addiction professionals, it is evident that one of the least accepted guiding principles of recovery is, in fact, that recovery is supported by addressing trauma. There are three prevailing reasons for this deficiency:

- (1) There is a reported lack of education and training specific to trauma treatment and recovery that is seen as available for and useable by addiction professionals.
- (2) There is a reported lack of practical and treatment user-friendly tools available to implement trauma-informed care in the treatment system.
- (3) Providing trauma-informed care necessitates the addiction professional to deal with one's own trauma history (if there is such) to reduce the intrusion of personal experience on the interaction with others in recovery, which is often very emotional and difficult.

Steps for Improvement

As a result of this discovery, it is imperative to include in future training curricula components specific to trauma-informed treatment and trauma-informed recovery support services that address these identified barriers. Special training must also be produced to address the following:

- There is overwhelming evidence in the literature, as well as from clinical experience in treating substance use disorders, that trauma is inflicted on those living among substance

abusers, including women, men, and their children (Jennings, 2004). In fact, trauma is inherent in substance use disorders due to the violence that interacts with substance use itself (Finkelstein & Markoff, 2004; Markoff & Finkelstein, 2007).

- Trauma is present in every population, culture, and race, no matter the degree of substance use issues. Historic layers of slavery, genocide, poverty, criminal justice disparity, and discrimination are elements of society that contribute to substance use disorders (e.g., resentment; low self-esteem; hopelessness). A recovery-orientation is inclusive of and sensitive to these factors.

Co-occurring Disorders

Addiction professionals are providing services every day to individuals who have co-occurring substance use and mental health disorders. In fact, 50 to 75% of all clients who are receiving treatment for a substance use disorder also have a diagnosable mental health disorder (McGovern, 2008). This translates into approximately 8.9 million adults (Community Recovery Resources, 2012). Further, of all psychiatric clients with a mental health disorder, 25 to 50% of them also currently have or had a substance use disorder at some point in their lives (Center for Substance Abuse Treatment, 2005). Only 7.4% of individuals receive treatment for both conditions with 55.8% receiving no treatment at all (Community Recovery Resources, 2012).

Due to this prevalence, and the movement to integrated care, it has become more important that addiction professionals are aware, trained, and able to serve individuals with co-occurring disorders. Prevalence rates will likely increase due to the Patient Protection and Affordable Care Act's expanding services and increasing access to integrated care for previously uninsured/underinsured clients.

It will be important to address the movement of the integration of substance use and mental health disorders and their relationship to recovery and the ROSC system at three levels: conceptual alignment, service practice integration (integrated versus parallel or sequential treatment), and contextual alignment (e.g., greater integration of policies, funding streams, and regulatory standards and monitoring) (Achara-Abrahams, Evans, & King, 2011; Gagne, White, & Anthony, 2007; White & Davidson, 2006; Davidson & White, 2007).

It is also important to incorporate the term "Dual Recovery" and the concepts of "person first" and transformation from "professional-centered" to "person-centered" through the "redefinition of the problems, issues, and challenges associated with these experiences from the perspective of the person himself or herself". (Davidson, Andres-Hyman, Bedregal, Tondora, Fry and Kirk, 2008). This includes the core components found in the recovery from mental health that are similar to the same core components found in the recovery of addictive disorders.

NAADAC's Activity

NAADAC has identified and worked to resolve two barriers within the addiction profession that impede full integration of recovery-oriented practices:

- (1) There is a lack of education and training resources specific to co-occurring disorders for addiction professionals. To meet this need, NAADAC worked with Hazelden to produce a training curriculum for addiction professionals specific to co-occurring disorders entitled, *Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know*. This course has been converted into an online course, manualized independent study course, face-to-face seminars, and Training-of-Trainer program.
- (2) There is a lack of a scope of practice and competencies necessary to treat co-occurring conditions. To address the deficiency, NAADAC, along with an expert panel in co-occurring disorders (including SAMHSA representatives), convened a summit in early March 2012 to discuss the competencies necessary for professionals to treat co-occurring disorders along with the inclusion of “Peer Recovery Support Specialists” as a defined scope of practice and career path. At the summit, four co-occurring peer recovery support specialists attended and shared their insights and experiences with the group. As a result of their cumulative efforts, an initial set of competencies and an outline for a scope of practice were developed. (See Appendix C for competencies draft and Appendix D for the draft scope of practice.)

Participation of Consumers and Family Members in Addiction Education and Practice

As reported earlier in this document, many of our early and current addiction professionals are persons or family members in recovery from substance use disorders. However, participation of the person in recovery and family members in the design, delivery, and evaluation of addiction services declined through the 1980s and 1990s. To return to a recovery-oriented model of care, re-involvement of these stakeholders is essential.

Some addiction professionals report that they do not have the funds to develop methods of incorporating client and family members into their education and treatment practice. Others report that it is difficult to incorporate family members due to time constraints and an already overburdened treatment system adapting to new reporting and electronic records requirements. Still others feel they have aspects of this approach in their alumni programs, but still need specific training on how best to engage current and former clients and family members in a greater professional/consumer partnership.

It will also be important to find new resources or bridge the current resources (treatment, ROSC, ATR, and general community) into a broader model that can be implemented into the general treatment community (White, 2009). It also means a shift in service practices that extends the continuum of care to include community outreach by peers and family members, pre-treatment services, peer and family participation during the treatment phase, long term “continuing care” that allows for peer support before and at official discharge from the treatment phase, case management and a long-term open door policy that allows for clients and family members to re-

engage in treatment programs for “booster” sessions. (Dennis & Scott, 2012). There are several models addressed earlier in this document that will inform the curricula development such as The Net Consumer Council in Philadelphia (Evans, Lamb, Mendelovich, Schultz, & White, 2007).

Through the Recovery to Practice Initiative, NAADAC included on its Advisory Board people in recovery, including family members in recovery, to participate in this process and offer feedback, suggestions, and resources to this overall effort. As a recovery-oriented training curriculum is developed, many of the contributions provided by consumer and family participation will influence the final product.

Peer Recovery Support Specialist (PRSS)

As mentioned earlier, the addiction profession has a strong foundation of peer involvement. The earliest addiction professionals were the first peer recovery support specialists informed by Alcoholics Anonymous. Over time, as the field became more professional, specific training in addictive disorders, counseling theory and methods, code of ethics, and higher education helped the field evolve. Much of this evolution arose as practitioners moved to conform with other well-established helping professions, such as social work and licensed counselors. The addiction professional strived to be recognized as an equivalent practitioner in order to have professional recognition at the state certification/licensure level, compete for third-party and Medicaid reimbursement, and to reduce stigma (White, 2000).

Necessity for Additional Training

It is clear from speaking with addiction professionals that there is a sense of discomfort and insecurity about where the newly arising peer recovery support specialist (PRSS) will “fit” into the overall services of the addiction treatment and recovery spectrum. A concern voiced by many is that government and managed care will replace current clinical addiction professionals with lower paid peer recovery support specialists. There is a general resentment that the education and work that is performed by addiction professionals may no longer be valued and appreciated.

NAADAC will strive in the development of future training curricula to address this anxiety by educating addiction professionals about the benefits of recovery-oriented systems of care, where current professionals fit, and how peer recovery support specialists can assist the current structure and services provided. In addition, recovery support specialists, other members of the addiction profession, and people in recovery will need to establish common visions, goals, and strategies for collaboration in order to meet this potential (Open Society Foundation and Faces & Voices of Recovery, 2012). As the number of peer support recovery specialists (PRSS) grows, they will have the opportunity to have more influence in their own professional development and as a part of the addiction profession.

NAADAC will continue its work to develop a scope of practice that builds in space for addiction professionals to serve at all levels, creating an open door approach with a clearer delineation of the various scopes of practice. In addition, NAADAC will continue to advocate for the use of

addiction professionals in the continuum of care with specific knowledge, skills, and competencies as outlined in the *Technical Assistance Publication (TAP) 21*.

Medication-Assisted Recovery

According to SAMHSA's Division of Pharmacologic Therapies (2012), medication assisted treatment (MAT) is "the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful, [compared to medication alone]. MAT is clinically driven with a focus on individualized patient care."

Historically, there has been resistance to medications for substance use disorders being used in the addiction profession. Bio-psycho-social-spiritual treatment has traditionally been the mainstay of substance use treatment programs. The history of this profession lies in the tradition of self-help programs that tend to minimize the need for any type of medication. The addiction profession is currently at a tipping point where a percentage of our current professionals are fearful and concerned that new pharmacotherapy medications may become a substitute for counseling and other recovery support services. Reportedly, there is resistance to pharmacotherapy due to social norms, personal and organizational philosophies, and other traditions within the addiction professional community and in some indigenous recovery communities (White & Coon, 2003; White, 2011).

The growth in the pharmacotherapy available to support addiction treatment and recovery has increased, particularly in the past few years. For example, the medication arsenal for alcohol dependence treatment has grown from only one pharmacotherapy (disulfiram) being available to four within the last seven years (acamprosate and two formulations of naltrexone). The same trend is noticeable for opioid dependence pharmacotherapies (methadone, naltrexone, and buprenorphine).

NAADAC's Activity

NAADAC has been working to produce evidence-based, practical, and applicable education and training on medication-assisted treatment and recovery presented in the context of an overall treatment plan that includes bio-psycho-social-spiritual components. NAADAC has developed several continuing education programs regarding pharmacotherapy, which include guidelines that help addiction professionals understand how pharmacotherapy works in the brain, its benefits, and who are appropriate candidates. Each of these trainings is infused with the Stages of Change model and Motivational Interviewing techniques.

Further, NAADAC has implemented many educational events at its national and regional conferences, in distance-learning materials, CDs, online courses, and webinars. Printed materials have been included in *Addiction Professional* magazine, the *NAADAC News* and other special publications and educational compendiums.

Steps for Improvement

It is clear from speaking with addiction professionals that more training to increase knowledge and reduce professional resistance is necessary to bring wide acceptance of this treatment method to the mainstay of addiction treatment and recovery.

It is also clear that the addiction professional needs to incorporate a long-term perspective of recovery from addiction, as a life-long process that includes their role in a recovery orientated system of care. Understanding this change in the context of their work environment to the community environment and the recovery oriented model, that may include “professional treatment” as a step along the path for all those persons that enter onto the path of recovery. There are many pathways to recovery and many do not begin with traditional treatment.

In addition, there are several critical issues related to the full integration of medication-assisted treatment within a ROSC framework, including defining the criteria for recovery status for patients in MAT (affirming medication-assisted recovery as a legitimate recovery pathway), defining recovery-oriented practices within MAT, integrating psychosocial and pharmacotherapeutic models of treatment, enhancing recovery mutual aid options for patients in MAT, and addressing public and professional stigma attached to MAT (White & Torres, 2010).

NAADAC will incorporate lessons learned and recommendations as stated above to best integrate medication assisted treatment within a recovery-oriented training curriculum.

Opportunities and Challenges: Curriculum Development and Training

As a result of information gathered through this Situational Analysis, NAADAC will create a recovery-based training curriculum for addiction professionals, with the intention of incorporating it into the national certification process for the workforce. NAADAC endeavors to create a curriculum that:

- (1) Educates addiction professionals about recovery-oriented systems of care (ROSC);
- (2) Educates addiction professionals about addiction recovery; and
- (3) Teaches competencies needed to integrate addiction recovery concepts into practice.

Target Audience

Based on this assessment, the most relevant target audience for a recovery-oriented addiction training curriculum is frontline addiction counselors who provide addiction treatment and recovery services. Addiction counselors typically perform the following activities (Bureau of Labor Statistics, 2012):

- Evaluate clients' mental and physical health, addiction, or problem behavior, and openness to treatment;
- Help clients develop treatment goals and plans;
- Review and recommend treatment options with clients and their families;
- Help clients develop skills and behaviors necessary to recover from their addiction or modify their behavior;
- Work with clients to identify behaviors or situations that interfere with their recovery;
- Teach families about addiction or behavior disorders and help them develop strategies to cope with those problems;
- Refer clients to other resources or services, such as job placement services and support groups; and
- Develop and conduct outreach programs to help people learn about addictions and destructive behaviors and how to avoid them.

Information gained through this Situational Analysis demonstrates the need for several training curricula for various audiences. NAADAC hopes to adapt the resultant training curriculum for other audiences in need in the future.

Opportunities and Challenges

This Situational Analysis forms the basis for determining strengths and identifying gaps to implementing a recovery-oriented approach to care among addiction counselors. This knowledge drives the ultimate curriculum design for the target population. The chart below outlines the opportunities and challenges regarding curriculum development, dissemination, and adoption of recovery-oriented practices for addiction counselors that arose out of this process:

	Challenges	Opportunities
Curriculum Development	<ul style="list-style-type: none"> ■ Lack of conceptual clarity of RM/ROSC and recovery planning ■ Lack of science-based answers to critical questions related to recovery and recovery-oriented practices; recovery-focused service practice are far ahead of recovery research 	<ul style="list-style-type: none"> ■ NAADAC has the expertise, experience, resources, networks, and capacity to develop a recovery-oriented training curriculum ■ NAADAC has many recovery-oriented educational products that are ready for dissemination or inclusion in this training curriculum, as well as resources from other organizations ■ Much of what is known has been summarized in ATTC RM/ROSC monograph series and SAMHSA/CSAT ROSC publications and can be called upon to inform this training curriculum ■ Demonstrate how RM/ROSC has drawn from earlier developments, e.g., cultural competence, trauma-informed care, strengths-based case management, assertive outreach, assertive follow-up, alumni and volunteer programs; show lineage and place RM/ROSC in context of historical evolution of the field ■ Great opportunity to bring together key stakeholders representing addiction/recovery research, specialty sector addiction treatment and diverse communities of recovery and recovery community organizations
Dissemination of Curriculum	<ul style="list-style-type: none"> ■ Not all ATTCs and all SSAs are involved in RM/ROSC-related training and technical assistance 	<ul style="list-style-type: none"> ■ New continuing education created for this project will fit within the current structure for approved CE credit and align with requirements for credentials already in existence ■ Any new continuing education (CE) hours developed by NAADAC through this Initiative will hold NAADAC's Approved Education Provider number, making it automatically accepted as continuing education credit by many state and national credentialing/licensing boards

		<ul style="list-style-type: none"> ■ NAADAC, ATTC network, SSA-sponsored training programs, state addiction counselor certification authorities, and the association of addiction educators provide a viable dissemination infrastructure ■ Technology is advancing and opening up new methods of service delivery and training
Adoption of Recovery-oriented Practices	<ul style="list-style-type: none"> ■ Inadequate funding to encourage recovery support services and training ■ Addiction counselors are somewhat resistant to change ■ Addiction counselors are concerned about the role of peer recovery support specialists, and therefore are somewhat resistant to ROSC ■ New generations of addiction counselors are not being exposed to these concepts in academic training programs ■ Some states have made significant strides in implementing ROSC but only a few are in the midst of comprehensive reform 	<ul style="list-style-type: none"> ■ Addiction professionals are early adopters of recovery concepts that are already infused in addiction practice ■ Addiction counselors are generally in agreement about key recovery definitions and guiding principles ■ Long history of involvement with mutual support groups ■ Recovery support services reduce costs and improve outcomes ■ Many recovery-oriented practices can be implemented with minimal additional financial resources ■ National and state regulation changes are slowly occurring to support implementation ■ RM/ROSC work over the past decade (e.g., in CT and Philadelphia) provide a body of experience, planning documents, transformation tools, training materials, etc. that could be adapted for nationwide dissemination ■ Many addiction counselors are already utilizing many recovery-oriented practices and concepts and can build on this foundation ■ Many organizations are embedding recovery-oriented concepts and policies into their organizational structure and will be eager to receive training

Recovery principles and practices can mostly likely be made to appeal to addiction professionals:

- Frame them as amplifying and extending the effects of traditional acute care model of interventions.
- Emphasize that RM/ROSC-related innovations are renewing and extending rather than replacing the best within the existing system of addiction treatment.
- Continue to clarify roles of the addiction counselor and peer recovery support specialist.
- Define how addiction counselors can best work with these new recovery support roles and with newly rising recovery community service institutions.

- Assure development of ethical guidelines for peer support services without simply adapting counselor codes of ethics and turning peer recovery support specialists into junior counselors.
- Emphasize training in trauma, cultural competency, co-occurring disorders, and collaborating with others.
- Emphasize the long-term perspective of recovery from addiction, as a life-long process that includes
- Train all addiction professionals on differences and legitimacy of scientific, clinical, and experiential ways of understanding and approaching addiction.

Approaching the recovery-oriented training curriculum from these angles will ensure its success.

Appendix A: NAADAC Leadership

NAADAC Executive Director

Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP

NAADAC Executive Committee

- **President** - Donald P. Osborn, PhD (c), LCAC
- **President-Elect** - Robert C. Richards, MA, NCAC II, CADC III
- **Secretary** - Roger A. Curtiss, NCAC II, LAC
- **Treasurer** - Edward Olsen, LCSW, CASAC, SAP
- **Past President** - Patricia M. Greer, BA, LCDC, AAC
- **Mid-Atlantic Regional Vice President** - Thomas Durham, PhD, LADC, CCS
 - Represents New Jersey, Delaware, Pennsylvania, Virginia, the District of Columbia, Maryland & West Virginia
- **Mid-Central Regional Vice President** - Stewart Turner Ball, LMFT, LCSW, LCAC, MAC
 - Represents Illinois, Indiana, Kentucky, Michigan, Ohio & Wisconsin
- **Mid-South Regional Vice President** - Greg Lovelidge LCDC, ADC III
 - Represents Arkansas, Louisiana, Oklahoma & Texas
- **North Central Regional Vice President** - Diane Sevening, EdD, CDC III
 - Represents Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota & South Dakota
- **Northeast Regional Vice President** - Barbara K. Fox, CAC, ICADC, LADC
 - Represents Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island & Vermont
- **Northwest Regional Vice President** - Gregory Bennett, MA, LAT
 - Represents Alaska, Idaho, Oregon, Montana, Washington & Wyoming
- **Southeast Regional Vice President** - Frances Patterson, PhD, MAC, CCJAS, QSAP, QCS
 - Represents Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina & Tennessee
- **Southwest Regional Vice President** - Kirk Bowden, PhD, MAC, LISAC, NCC, LPC
 - Represents Arizona, California, Colorado, Hawaii, New Mexico, Nevada & Utah
- **Certification Board Chair** - James A. Holder III, MA, MAC, LPC, LPCS

Appendix B: Addiction-Related Publications*

<i>Addiction</i>	<i>Drugs: Education, Prevention and Policy</i>
<i>Addiction Abstracts</i>	<i>International Journal of the Addictions</i>
<i>Addiction Biology</i>	<i>Journal of Addiction Medicine</i>
<i>Addiction Professional</i>	<i>Journal of Addictions and Offender Counseling</i>
<i>Addiction Research and Theory</i>	<i>Journal of Addictions Nursing</i>
<i>Addiction Science and Clinical Practice</i>	<i>Journal of Addictive Diseases</i>
<i>Addictive Behaviors</i>	<i>Journal of Alcohol and Drug Education</i>
<i>Addictive Disorders and Their Treatment</i>	<i>Journal of Child and Adolescent Substance Abuse</i>
<i>Alcohol</i>	<i>Journal of Drug Education</i>
<i>Alcohol and Alcoholism</i>	<i>Journal of Drug Issues</i>
<i>Alcohol Research and Health</i>	<i>Journal of Dual Diagnosis</i>
<i>Alcohol, Other Drugs, and Health: Current Evidence</i>	<i>Journal of Ethnicity in Substance Abuse</i>
<i>Alcoholism Treatment Quarterly</i>	<i>Journal of FAS (Fetal Alcohol Syndrome) International</i>
<i>Alcoholism and Drug Abuse Weekly</i>	<i>Journal of Groups in Addiction and Recovery</i>
<i>Alcoholism: Clinical and Experimental Research</i>	<i>Journal of Ministry in Addiction and Recovery</i>
<i>American Journal of Drug and Alcohol Abuse</i>	<i>Journal of Psychoactive Drugs</i>
<i>American Journal on Addictions</i>	<i>Journal of Social Work Practice in the Addictions</i>
<i>Contemporary Drug Problems</i>	<i>Journal of Studies on Alcohol and Drugs</i>
<i>Counselor</i>	<i>Journal of Substance Abuse Treatment</i>
<i>Drug Dependence, Alcohol Abuse and Alcoholism</i>	<i>Journal of Substance Use</i>
<i>Drugs and Alcohol Dependence</i>	<i>Journal of Teaching in the Addictions</i>

<i>Journal of the International Association of Addictions and Offender Counselors</i>	<i>Science and Practice Perspectives</i>
<i>Prevention Researcher</i>	<i>Student Assistance Journal</i>
<i>Psychology of Addictive Behaviors</i>	<i>Substance Abuse</i>
<i>Quarterly Journal of Studies on Alcohol and Drugs</i>	<i>Substance Abuse Treatment, Prevention, and Policy</i>
<i>Quarterly Review of Alcohol Research</i>	<i>Substance Use and Misuse</i>
<i>Recent Developments in Alcohol</i>	

*Some of these publications are no longer in existence, but archived versions are still available.

Appendix C: Co-occurring Disorders Competencies

Practice Dimension: Service Coordination

Element: Implementing the Service Plan

Competency 1: Initiate collaboration with the referral source

Competency 2: Review, and obtain interpretations of all relevant screening, assessment, and initial plan.

Competency 3: Confirm the individual's stage of readiness.

Competency 4: Complete necessary administrative procedures for admission to treatment.

Competency 5: Create person-centered treatment and recovery goals:

- The nature of services
- Clients' rights and responsibilities
- Provider responsibilities

Competency 6: Coordinate activities with services provided to the person by other resources.

Practice Dimension: Service Coordination

Element: Coordinated Care

Competency 7: Summarize the person's personal and cultural background, treatment plan, recovery progress, and factors inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment.

Competency 8: Understand the terminology, procedures, and roles of other disciplines related to the treatment of co-occurring disorders.

Competency 9: Contribute as part of a multidisciplinary treatment team.

Competency 10: Apply confidentiality rules and regulations specific to state and federal regulations.

Competency 11: Demonstrate respect and nonjudgmental attitudes toward individuals in all contacts with community professionals and agencies.

Practice Dimension: Service Coordination

Element: Continuing Assessment and Service Planning

Competency 12: Apply placement, continued stay, and discharge criteria for each modality on the continuum of care.

Competency 13: Maintain ongoing contact with the individual and involved significant others to mutually ensure relevance of the service plan.

Competency 14: Understand and recognize stages of change and other signs of progress.

Competency 15: Assess treatment and recovery progress, and, in consultation with the Individual and significant others, make appropriate changes to the service plan to ensure progress toward goals.

Competency 16: Describe and document the Individual's and service provider's process, progress, and outcomes.

Competency 17: Use accepted outcome measures.

Competency 18: Conduct continuing care, relapse prevention, and planning with the Individual and involved significant others.

Competency 19: Document service coordination activities throughout the continuum of care.

Practice Dimension V: Counseling

Element: Individual Counseling

Competency 20: Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.

Competency 21: Facilitate the client's engagement in the treatment and recovery process.

Competency 22: Work with the client to establish realistic, achievable goals consistent with attracting, achieving, and maintaining wellness and recovery.

Competency 23: Promote client knowledge, skills, and attitudes that contribute to a positive change or outcome.

Competency 24: Work appropriately with the client to recognize and encourage all behaviors consistent with progress toward mutually-established goals.

Competency 25: Encourage and reinforce client actions determined to be beneficial in progressing toward mutually-established goals.

Competency 26: Recognize how, when and why to involve the client's significant others in enhancing or supporting the mutually-established plan.

Competency 27: Promote client knowledge, skills, and attitudes consistent with the promotion and maintenance of health and prevention of diseases.

Competency 28: Facilitate the development of basic and life skills associated with wellness and recovery.

Competency 29: Employ person-centered counseling strategies that honor the unique characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status.

Competency 30: Apply crisis prevention, intervention, and management skills when indicated.

Competency 31: Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining wellness and recovery.

Practice Dimension V: Counseling

Element: Group Counseling

Competency 32: Describe, select, and use evidence-based and promising practice strategies from accepted and culturally informed models for group counseling with clients with co-occurring disorders.

Competency 33: Carry out the actions necessary to form a group, including but not limited to determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods.

Competency 34: Facilitate the entry of new members and the transition of exiting members.

Competency 35: Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type.

Competency 36: Understand the concepts of process and content, and shift the focus of the group when such a shift will help the group move toward its goals.

Competency 37: Describe and summarize the client's behavior within the group to document the client's progress and identify needs for modification of their plan.

Practice Dimension V: Counseling

Element: Counseling Families, Couples, and Significant Others

Competency 38: Understand the characteristics and dynamics of families, couples, and significant others affected by co-occurring disorders.

Competency 39: Be familiar with and competently use models of diagnosis and intervention for families, couples, and significant others, including extended, kinship, or tribal family structures.

Competency 40: Facilitate the engagement of selected members of the family or significant others in the wellness and recovery process.

Competency 41: Assist families, couples, and significant others in understanding the interaction between the family system and co-occurring disorders.

Competency 42: Assist families, couples, and significant others in adopting strategies and behaviors that sustain wellness and recovery and maintain healthy relationships.

Practice Dimension VI: Client, Family and Community Education

Competency 43: Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.

Competency 44: Describe factors that increase the likelihood for an individual, community, or group to be at risk for, or resilient to, psychoactive substance use disorders.

Competency 45: Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.

Competency 46: Describe warning signs, symptoms, and the course of substance use disorders.

Competency 47: Describe how substance use disorders affect families and concerned others.

Competency 48: Describe the continuum of care and resources available to the family and concerned others.

Competency 49: Describe principles and philosophy of prevention, treatment, and recovery.

Competency 50: Understand and describe the health and behavior problems related to substance use, including transmission and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C, and other infectious diseases.

Competency 51: Teach life skills, including but not limited to stress management, relaxation, communication, assertiveness, and refusal skills.

Practice Dimension VII: Documentation

Competency 52: Demonstrate knowledge of accepted principles of client record management.

Competency 53: Protect rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.

Competency 54: Prepare accurate and concise screening, intake, and assessment reports.

Competency 55: Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.

Competency 56: Record progress of client in relation to treatment goals and objectives.

Competency 57: Prepare accurate and concise discharge summaries.

Competency 58: Document treatment outcome, using accepted methods and instruments.

Practice Dimension VIII: Professional and Ethical Responsibilities

Competency 59: Adhere to established provider codes of ethics that define the context within which the provider works to maintain standards and safeguard the client.

Competency 60: Adhere to Federal and State laws and agency regulations regarding the treatment of co-occurring disorders.

Competency 61: Interpret and apply information from current promising and evidence-based practices to improve client care and enhance provider growth.

Competency 62: Recognize the importance of individual's uniqueness and apply this understanding to clinical practice in providing services for co-occurring disorders.

Competency 63: Use a range of supervisory options to process personal feelings and concerns about clients.

Competency 64: Conduct self-evaluations of provider performance applying ethical, legal and providers standards to enhance self-awareness and performance.

Competency 65: Obtain continuing education regarding co-occurring disorders.

Competency 66: Participate in ongoing supervision and consultation.

Competency 67: Develop and use strategies to maintain one's physical and mental health.

Appendix D: Co-occurring Disorders Scope of Practice

<i>Areas of Professional Practice</i>	<i>COD Support Provider</i>	<i>COD Associate</i>	<i>COD Provider</i>	<i>Clinical COD Provider</i>	<i>Independent COD Provider / Supervisor</i>	Client/ Patient	<i>Peer Support Specialist</i>	<i>Peer Support Supervisor</i>	<i>Peer Support Coordinator</i>	
Clinical Evaluation										
Clinical Evaluation, including screening, assessment and diagnosis of SUDs and CODs										
Diagnostic Impression and SBIRT										
Treatment Planning for SUDs and CODs, including initial, ongoing, discharge, and planning for relapse prevention										
Monitor Treatment Plan and Compliance										
Referral										
Service Coordination and Case Management for CODs										
Service Coordination and Case Management for SUDs										
Counseling, therapy and trauma informed care with individuals, families, and groups										
Counseling, therapy and trauma informed care with individuals, families and groups in the areas of SUDs and CODs										
Psycho-educational Counseling of individuals, families and groups										
Client, Family, and Community Education										
Documentation										
Professional and Ethical Responsibilities										
Clinical Supervisory Responsibilities for all Categories of SUD Counselors										
Clinical Supervisory Responsibilities for Categories 1 and 2 and SUD Technicians										
Clinical Supervisory Responsibilities for all categories of SUD Counselors										

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