

## State of the New Recovery Advocacy Movement

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Amplification of Remarks to the Association of Recovery Community Organizations  
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It is always good to be with old friends, friends in recovery and friends of recovery. It is a special pleasure to finally meet some of you face-to-face who I have corresponded with for so many years. As I entered the worlds of addiction treatment and recovery in the late 1960s, I witnessed the end of a very dark era in our country—an era in which those with alcohol and other drug problems festered in the “drunk tanks” of local jails and the “back wards” of aging state psychiatric hospitals or died alone bereft of hope. Few resources existed in most communities outside the rooms of mutual aid fellowships.

It would have been unthinkable in those early days that I would live to see a national network of addiction treatment and recovery support resources and the rising cultural and political mobilization of people in recovery. I could not have conceived of a day when I would witness more than 100,000 people in recovery marching publicly as far as the eyes could see or that I would one day stand before leaders of new recovery advocacy organizations from all over the United States. And yet we all witnessed the unprecedented numbers in recent Recovery Month celebration events, and I am here today living out the second of those unthinkable visions.

I have been invited as the historian of this movement to share some thoughts with you about the current state of recovery advocacy and support in the United States. In the few minutes we have together, I want to share some of my personal perspectives on our accomplishments to date, current and anticipated threats, and the movement’s next stages, strategies, kinetic ideas, and frontier issues.

### **New Recovery Advocacy Movement Achievements**

We would not be here today if those at the center of this emerging movement in the late 1990s and early 2000s had not made some very good decisions. I want to record some of the decisions that in retrospect I think were most important.

*Historical Continuity.* The first thing we got right was maintaining historical continuity with, and paying tribute to, earlier recovery advocacy efforts. We honored the past and continuing achievements of the National Council on Alcoholism and Drug Dependence (NCADD), the Johnson Institute as well as the earlier work of such organizations as the Society of Americans for Recovery (SOAR). By entering the alcohol and drug problems arena from a position of gratitude, humility, and respect and by grounding our movement in core recovery values, we minimized competition and conflict with kindred individuals and organizations. The embrace of such a partnership model continues to serve us very well.

*Decentralized Leadership.* Social movements are often fueled by charismatic leaders who are then prone to wrap themselves in closed organizations that become progressively

disconnected from their grassroots constituencies. Perhaps because of our collective character (organizing people in recovery has been compared to trying to herd cats), we have avoided the pitfalls of aligning ourselves under the umbrella of a charismatic leader, and we have maintained our local, grassroots focus. I can recall early on the confusion of the media when we were asked who the leaders were of this new movement and we declared either that we had no leaders or that we were all leaders. We got this right.

*Cultural and Recovery Pathway Diversity.* What we have achieved was born within a profound respect for the diversity of recovery experience and the legitimacy and wonder of such diversity. We spoke of a rainbow and a coat of many colors to capture our vision of a most culturally diverse movement, and we shared an ecumenical vision of a day when AA and NA members would walk beside people in secular recovery, faith-based recovery, medication-assisted recovery, and natural recovery with each of us not wearing our pathway identities but a larger identity: people in long-term recovery.

*“The Little Engine that Could”.* We decided early on to act as if we were a movement of import until we became one. We began referring to ourselves nationally and locally as a movement, acting far more bold than our early numbers would have warranted, and we documented our history via papers, recorded interviews, and visual images in the belief that what we were doing was historical and thus important to document. It was and is.

*Kinetic Ideas.* As early as 2000, five simple ideas emerged from the very heart of the movement—ideas that were foundational and kinetic (capable of inspiring action). Those five ideas were: 1) addiction recovery is a living reality for individuals, families, and communities, 2) there are many (religious, spiritual, secular) pathways to recovery, and all are cause for celebration, 3) recovery flourishes in supportive communities, 4) recovery is a voluntary process, and 5) recovering and recovered people are part of the solution: recovery gives back what addiction has taken from individuals, families, and communities. In retrospect, the selection of this particular set of ideas was critical to avoiding the schisms that have destroyed so many social movements. The first two of these ideas became the foundation for much of the consciousness raising and mobilization that went on in the early years and that continues today.

*Core Strategies.* The vision in the late 1990s was to change public attitudes and public policies to create recovery-friendly communities. We believed that such communities could shorten addiction careers, support individuals and families in long-term recovery, and ultimately break intergenerational cycles of addiction within our families, neighborhoods, and communities. As early as 2000, eight core strategies were being pursued within newly formed recovery community organizations (RCOs).

<b>Early Core Strategies of the New Recovery Advocacy Movement</b>
<ol style="list-style-type: none"><li>1. <u>Building strong, grassroots recovery community organizations (RCOs)</u> and linking these RCOs into a national movement that would develop recovery leaders, offer opportunities for the recovery community—people in recovery, family members, friends, and allies—to express their collective voice, respond to community-identified recovery support needs, and provide a forum for community service.</li><li>2. <u>Advocating for meaningful representation and voice</u> at local, state, and federal policy levels for people in recovery and their family members on issues that affect their lives.</li></ol>

3. Assessing needs related to the adequacy and quality of local treatment and recovery support services.
4. Educating the public, policymakers, and service providers about the prevalence and pathways of addiction recovery.
5. Developing human and fiscal resources by expanding philanthropic and public support for addiction treatment, recovery support services, and recovery advocacy and by cultivating volunteerism within local communities of recovery.
6. Creating recovery community centers that make recovery visible on Main Street and provide a setting for non-clinical, peer-based recovery support services, supports, and activities.
7. Celebrating recovery from addiction through public events (recovery marches, rallies, concerts) that offer living proof of the transformative power of recovery.
8. Supporting research that illuminates the pathways, processes, stages, and styles of long-term personal/family recovery.

Several things made development and refinement of these strategies possible, but two were critical. First was creation of a mutual learning community that brought RCO leaders together to expand their knowledge, develop expertise, and cultivate and refine best practices. The early development of this network was made possible by the networking that occurred in tandem with NCADD meetings and meetings of the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP) grantees. These early RCO exchanges set the stage for the historic 2001 Recovery Summit in St. Paul, Minnesota, the founding of Faces and Voices of Recovery, and the subsequent development of the Association of Recovery Community Organizations (ARCO). Faces and Voices of Recovery and ARCO have since provided the connecting tissue that links RCOs throughout the country. Collectively, these forums provided a mechanism for RCO leaders to share what was working and not working at local levels and to generate consensus on issues critical to the national movement.

A second influence on strategy development was the early decision to use formal data collection and analysis to formulate and refine movement strategy and tactics. An early example of that was the Peter Hart Public Opinion Survey on recovery in which we discovered to our dismay that most Americans had little recognition of the larger number of Americans living in long-term stable recovery and instead saw recovery as a process of trying to stop alcohol and other drug use but not the achievement of this goal.

*Message Clarity.* The data collection and analysis allowed us to formulate a clear set of messages that could be used by RCOs throughout the country and would be disseminated via “message training” that clarified the meaning of recovery and reality of long-term recovery in public communications. A further critical step in that message clarity was the work of detailing how advocacy could be done in ways that were completely in alignment with the anonymity traditions of 12-Step recovery programs—a position recently reaffirmed via a widely disseminated communication from the [General Service Office of Alcoholics Anonymous](#).

*Early Strategic Partnerships.* As the movement began to spread, we needed models that could guide how RCOs could relate to and collaborate with a wide spectrum of organizations. These models emerged from several key partnerships including with the Center for Substance Abuse Treatment at the national level and models of collaboration with state and municipal organizations that were pioneered by the Connecticut Community of Addiction Recovery and the work of PRO-ACT in the City of Philadelphia. Later, the Association of Persons Affected by

Addiction in Dallas collaborated with a major managed behavioral healthcare organization on what has become a model of private reimbursement for peer recovery support services.

*Support for Movement Globalization.* Another early thing we got right was extending ourselves to support rising recovery advocacy movements in the UK, Asia, Africa, Australia, and Canada. We did this by accepting invitations to speak in these countries and by hosting innumerable visits from recovery advocates across the globe. The fruits of those efforts are quite remarkable, such as major recovery parades in four Japanese cities in recent months—something that would have been unthinkable during our first visits there in 2007. The service ethic that inspired the recovery advocacy movement in the U.S. is now reaching around the world.

*Early Advocacy and Peer Recovery Support Development Successes.* As a result of the above key decisions, we have much to be proud of in 2013. We have witnessed:

- increased recovery representation at national, state, and local policy levels and key policy successes,
- the emergence of recovery as an organizing paradigm for addiction policy and service practice,
- major efforts to reconnect addiction treatment with the larger and more enduring processes of personal/family recovery via models of sustained recovery management and recovery-oriented systems of care,
- mass mobilization of communities of recovery via highly successful recovery celebration events, e.g., marches, rallies, festivals, and town meetings,
- the spread of new recovery support institutions—RCOs, recovery community centers, recovery residences / National Association of Recovery Residences, recovery schools / Association of Recovery Schools, recovery industries, recovery ministries,
- exponential growth of peer recovery support services (PRSS), new peer service roles (e.g., recovery coaches) and PRSS practice standards (Council on Accreditation of Peer Recovery Support Services), and
- increased interest in recovery within the addictions research community.

Today, the new recovery advocacy movement in America is coming of age.

### **Current and Anticipated Threats**

To acknowledge our achievements to date is not to ignore significant threats—some common to all social movements and some unique to the recovery advocacy movement. Here are some current and anticipated threats.

*Mobilization without Institutionalization.* All social movements risk mistaking methods for mission and getting frozen at an early stage of movement development. We must avoid infatuation with the growing numbers of people participating in recovery celebration events and continually ask and answer, “Mobilization for what purpose?” Mission clarity is critical to movement maintenance.

*Implosion.* All social movements at national and local levels are prone to centralized leadership, ideological closure, leadership and core membership exhaustion and the collapse of key organizations. These processes often spawn major schisms and mass movement defections. The greater the centralization of leadership, the greater is the risk of such things occurring.

Strategies of leadership development, succession planning, and participatory models of decision-making are crucial preventatives and antidotes to such processes.

*Colonization/Professionalization/Commercialization.* All social movements are at risk of being hijacked by more powerful forces within their operating environment. Because of the early alignment with the addiction treatment system following the 2002 CSAT/RCSP decision to no longer fund recovery advocacy efforts and to only fund recovery support services, there has been a parallel shift in emphasis in the larger movement toward PRSS with a somewhat diminished focus on advocacy and recovery community development and mobilization activities. This has exerted pressure towards professionalization and commercialization of PRSS. My primary warnings in this area are as follows. If the recovery advocacy movement morphs solely into a PRSS appendage to the addiction treatment system, the movement will have failed and will recreate conditions that will set the stage for a future revitalized recovery advocacy movement. (One could argue that this was in fact the earlier fate of the recovery advocacy movement of the mid-twentieth century.) If PRSS become fully professionalized and overly commercialized, they will lose their experiential foundation and do substantial harm to the voluntary service ethic that has long been the foundation of communities of recovery in the U.S. Accreditation, and credentialing related to PRSS must come from within or be controlled by central institutions within the recovery advocacy movement to avoid such pitfalls.

*Marginalization.* The movement faces two major threats of marginalization into insignificance. If we cannot achieve significant representation/influence in restructuring of addiction treatment within the current processes of health care reform, we risk PRSS becoming disconnected from these mainstream systems, which would mean that the majority of persons seeking professional help would not have PRSS integrated as part of their treatment and continuing care plans. There are also widespread initiatives to integrate addiction treatment with mental health and primary health care. There is a risk that recovery representation and core knowledge of addiction recovery could be lost within such integration initiatives, leading to a death by dilution of addiction treatment and the recovery advocacy movement. It is quite appropriate for us to reach out to sister movements, but great care must be taken to keep our “eyes on the prize” and not lose our addiction recovery focus.

*The Coming Professional/Cultural Backlash.* No successful social movement has avoided a cultural backlash. Such backlashes are spawned by excesses within the movement itself and by established interests who experience threat from the movement’s achievements and potential power. Such backlashes are intensified when they allow full expression of dormant prejudices related to highly stigmatized issues, e.g., addiction.

I would point out three potential wolves at our door seeking vulnerability points of the movement to exploit for their benefit. The first is the media. The same media that extols the virtues of the newly visible recovery advocate and thrusts the advocate on a high cultural pedestal will also lead the vulture-like feeding frenzy at the first sign of the fall of such a leader. The media’s primary mission is to sell products, which they do by cultivating themes antithetical to recovery stability and quality: crisis, drama, hysteria, emotional excess, self-promotion, self-indulgence and shame. The media can use us just as we can use the media, but let’s be very clear: the media as a social institution is not our friend.

The second wolf at our door is a sector of the addiction treatment industry that fears the potential power and influence of politically mobilized recovery communities. This sector includes organizations that view addicted people as a crop to be harvested for financial profit, organizations who fear close scrutiny of addiction treatment outcomes, those who fear the

demands a mobilized recovery community will make to elevate the quality of addiction treatment, and those who fear the diminished allocation of status and resources to treatment organizations that may accompany a broadened focus on long-term addiction recovery.

The third wolf at our door represents the interests of the alcohol, tobacco, pharmaceutical, and illicit drug industries. Such powerful industries have little concern with our recovery support activities, but some of our advocacy activities pose great threats to their future. Of particular concern would be our exposure of the predatory practices of these industries; our efforts to expand recovery-friendly, ATOD-free space within local communities; our support for limitations on ATOD advertising (particularly to vulnerable populations); and our support for increased ATOD taxation to offset social costs of ATOD use and to support ATOD prevention, treatment, and recovery support efforts. These industries as a collective force are not our friends and constitute very powerful and formidable opponents. There are major ethical issues related to any relationship with these industries, including acceptance of proffered funding.

When these forces coalesce, attacks to undermine the credibility of recovery advocacy organizations and leaders could be quite personal and intense. There are several steps needed to protect our leaders and our organizations. These steps include 1) rigorous adherence to financial stewardship, best practices related to fiscal management, and financial transparency of our organizations, 2) development of ethical guidelines and ethical decision-making models to guide recovery advocacy and peer recovery support services, 3) rigorous self-evaluation and training related to how private behavior could harm leadership and organizational credibility, and 4) making sure the “faces and voices” of this movement are diverse and constantly rotating to minimize the targeting of any core leadership. Finally, when any person who has been a visible part of the movement experiences a fall from grace, whether through a recurrence of addiction or other delegitimizing behavior, it is important that we offer that person our full support for recovery re-stabilization, as we would for all others in need of such support.

## **The Future of the Movement**

I want to reference four issues to open the discussion of the future of the recovery advocacy movement in the U.S.

*Continual Representation Checks.* First, as we go forward, it is important that we regularly self-inventory the degree of recovery representation within our organizations, as well as the authenticity (e.g., avoidance of double agency<sup>1</sup>) and diversity (e.g., gender/age/culture/pathway representation) of such representation. The degree, authenticity, and diversity of indigenous representation often erode as social movements evolve toward formal organizations. The legitimacy and continued renewal of the new recovery advocacy movement rests on these representation issues.

*Clarity of Advocacy Agenda.* The future of the new recovery advocacy movement also rests on our ability to freshen and contextually refine the vision and goals of the movement. These must be defined at both national and local levels through processes of consensus-building. I will shortly note new elements within that agenda that I think are important for us to consider as we move forward.

*Institution Building.* We are moving beyond the stage of consciousness raising and cultural/political mobilization to the stage of institution building. We are enhancing the

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<sup>1</sup> Double agency is an ethical issue that occurs when a person presents themselves as a person in recovery but actively represents other undeclared personal or institutional interests.

infrastructures of existing RCOs; facilitating the geographical dispersion of RCOs; and expanding and creating new recovery community centers, recovery residences, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-focused sporting clubs/events, and recovery media outlets. These are the structures through which the movement will sustain itself in the years to come.

*Cultural Development.* We are also well on our way to constructing an ecumenical culture of addiction recovery in the United States with its own language, symbols, rituals, values, literature, art, music, theatre and film products, sporting teams, etc. Its ecumenical nature implies that it incorporates elements from diverse pathways of recovery but is distinct from and unaffiliated with any particular pathway of recovery. What such a culture provides is the psychological and social space within which one can recover within a local community—space that is particularly important for people who have been deeply enmeshed in and are trying to extricate themselves from a culture of addiction.

*Economic Development.* I believe the next stage of movement development will be one of economic development. I envision a day soon when recovery community centers across the country will collaborate with recovery-friendly businesses and serve as incubators for small businesses started by and employing people in recovery. Such businesses will be particularly valuable for people in recovery who have been marginalized from the mainstream economy and/or who face special obstacles to employment due to their re-entry into the community from jail or prison. And I see a growing cadre of recovery philanthropists (large and small) investing in this economic development as well as supporting our core organizations.

## **Constituency Expansion**

Another critical step as we move forward is in the area of constituency expansion. The involvement of Native American organizations (particularly White Bison, Inc.) and recovery advocacy organizations with high African American representation (e.g., in cities such as Atlanta, Baltimore, Chicago, Dallas, Detroit) exerted a profound influence on the early recovery advocacy movement, but greater effort is needed to mobilize recovery constituencies within Hispanic and Asian Communities.

I have been particularly excited by the development of Young People in Recovery (YPR). We have the largest generation of young people in recovery in history. Focused leadership development efforts over the next few years could reap rewards for decades. We should all be supporting YPR infrastructure expansion and support continued cultural diversification as the youth branch of the recovery movement expands.

Another growing group that could exert a profound influence on the future of the movement is retirees in recovery—a group that brings an enormous reservoir of skills, time, and financial resources.

Family members of individuals recovering from addiction have been welcomed since the early days of the new recovery advocacy movement, but we are now witnessing something on an unprecedented scale in the U.S. and other countries: the mobilization of people who are transforming grief over the drug-related death of a loved one into advocacy and political action. It remains to be seen whether these grieving family and friends will form their own movement or become a new constituency and a new set of voices within the recovery advocacy movement. I am suggesting that we warmly welcome them at all levels of the movement and that their support be embraced within the movement's recovery focus.

## Next Kinetic Ideas

There are several newly emerging and interconnected ideas worthy of infusion into our work. Here are those I consider the most important.

*[Recovery is Contagious.](#)* This phrase suggests that recovery can be “caught”—interpersonally transmitted—before it is chosen. Recovery is spread through exposure to *[recovery carriers](#)* (“*wounded healers*”)—people who make recovery infectious through their persona and their love and service to those still suffering. Positing the contagiousness of recovery counters the ideas that people must “hit bottom” before recovery is possible and that family and community are powerless to affect addiction until the addicted person is “ready” for recovery. This notion of contagiousness suggests quite the opposite: that recovery initiation has as much to do with hope as with pain, and that hope can be elicited through interpersonal encounters with people living vibrant, meaningful lives in recovery.

*[Recovery prevalence](#)* (*the number of people in addiction recovery within a community*) can be strategically increased by increasing the density of *[recovery carriers](#)* within that community. This can be done by recovery resource mapping—identifying areas of a city in greatest need of recovery support resources—and infusing such resources via assertive outreach and recovery community development activities. Increasing the visibility of recovery carriers counters community pessimism related to addiction by elevating recovery as an expectation by affected persons, professionals, and the community.

*Recovery prognosis is predicted as much by [community recovery capital](#) as by personal vulnerabilities and assets; recovery-hostile communities can be transformed into [recovery-friendly communities](#).* We are currently placing people with severe, complex, and prolonged addiction careers within treatment designs whose brevity and low intensity produces little likelihood of a positive recovery outcome. When resumption of addiction then occurs, as it does so often, the individual is blamed and punished (via divorce, loss of child custody, revocation of probation, job dismissal, expulsion from school, etc.) on the grounds that “they had their chance and blew it.” I’m suggesting that such a scenario was not a chance, but a set-up for failure—and as much a community systems failure as a personal failure. Recovery stability is enhanced by effective, accessible, affordable resources designed to support long-term personal and family recovery. Anything less is analogous to treating a bacterial infection with half of the needed antibiotics and then blaming the patient when the infection returns in a more intractable form.

*Whole communities have been wounded by severe AOD (alcohol and other drug) problems and are in need of a process of [community recovery](#).*

*Personal and community recovery is enhanced by expanding [recovery-friendly space](#)—physical, psychological, and cultural space where recovery can flourish. Such space can be measured and expanded through strategic and sustained initiatives of recovery community resource development. I think this idea of recovery-friendly space will become increasingly important to the future work of the movement and that we will come to fully appreciate the powerful role people in recovery can play as [catalysts of community healing](#) via their person/family-centered and broader community service work*

*What we don’t know about recovery is killing people.* Recovery advocates have been calling upon (i.e., begging and pleading) the National Institutes of Health—the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism—to pursue a [recovery research agenda](#) for more than a decade. The prolonged governmental failure to

develop and substantially fund a clearly define, solution-focused, recovery research agenda to elucidate the prevalence, pathways, processes, stages, and styles of personal/family recovery contributes to the loss of life from addiction and compromises the quality of life of individuals and families in recovery. Some of the most critical questions related to recovery initiation and maintenance—the questions most critical to individuals/families needing, seeking and in recovery--remain unanswered. This is completely unacceptable. Our approach to NIH/NIDA/NIAAA on this critical need must become more confrontational and engage the constituencies and political powers to which the Institutes are accountable. Media dissemination of the existing research focus with its obsession with “hijacked brains” may, by increasing rather than decreasing social stigma related to addiction, be doing more harm than good to people in need of, seeking, and in recovery.

## **Frontier Issues**

There is still much work to be done laying the foundation for the recovery advocacy movement at national, state, and local levels. Early movement stages must be continually replicated and refined via consciousness raising, mass mobilization, RCO infrastructure enhancements, advocacy on emerging issues, and peer support service refinements, but there are also frontier issues on the horizon for us to consider. Here are a few.

*Recovery Responsibilities.* I suggest a shift in the public face of the movement from a focus on the rights of people in recovery (though our advocacy work will continue) to a focus on *recovery responsibilities* to family and community. This would shift our emphasis from self to service. Addiction has been correctly portrayed as destructive to family and community fabric; we must use science and our stories to demonstrate recovery as a healing and restorative force within the life of family and community.

*Family and Community Service* constitute the needed third leg of the movement—along with advocacy and peer recovery support. That third leg provides a means of both making needed amends to family and community and elevating the visibility of the service ethic beyond service to individuals in recovery. The “face” of the movement must expand beyond recovering individuals—whom the public tends to view as self-centered and self-indulgent due to the media’s obsession with self-destructing celebrities—to the image of families in recovery. The demonization of the person affected by addiction will continue until we positively (and visually) nest that person in the context of family, friends and community. In that same vein, it is also time we explored more consciously an expanded role for children within the movement—a potential that was critical within the respective histories of the civil rights and LGBT rights movements.

*Breaking Intergenerational Cycles.* I think THE recovery advocacy issue of the 21<sup>st</sup> century is breaking cycles of intergenerational transmission of addiction and related problems. We need to assemble the best minds and best science we can muster to formulate a decades-long plan to achieve this goal and then mobilize the political power to initiate and sustain such an effort.

*Health Status of People in Recovery.* Marketing of the acute care model of addiction treatment in the U.S. feeds the illusion that people go through brief treatment, initiate recovery, and live happily ever after. While there are people whose recovery stories have that flavor, this portrayal of recovery masks what is often a much more complex process of recovery initiation, stabilization, and maintenance. It also fails to accurately portray the many burdens—including

health burdens often brought into the long-term recovery process—burdens clearly revealed in a recent [recovery prevalence and health study from Philadelphia](#). The recovery advocacy movement of the future will recognize such enduring challenges and expand its focus beyond recovery initiation to a broad spectrum of advocacy efforts, programs, and services aimed at enhancing the health and quality of life of individuals and families in long-term recovery. Those efforts must include a focus on the issue of nicotine addiction, which continues as a major cause of disease and death for people in recovery from other addictions.

*Recovery Advocacy/Support within the U.S. CJ/Jail/Prison System.* The United States has the largest sequestered and monitored population of addicted people in the world. We as a movement should be recruiting and developing indigenous recovery leaders within the very heart of these institutions. I believe we will see a major recovery advocacy movement rise within U.S. jails and prisons in the next decade. It is important we not turn our back on this rising movement. We need to help seed this movement, build recovery supports within the criminal justice system, and help create recovery-supportive pathways for community reentry.

### **Leadership Self-maintenance**

What my historical perspective has given me is an understanding that our present work is nested within a prolonged historical struggle to forge personal, community, and cultural solutions to the most severe and complex addictions. Thus my mantra to all recovery advocates is: “Pace yourself; this is a marathon!” So the question remains, “How does one sustain oneself through such a long journey?” I have seen people burn themselves out (and occasionally self-destruct) from the intensity of this work, but I have also observed people doing this work with great dignity, grace, and health for decades. I’ve found four daily rituals that distinguish the lives of this latter group that I would like to share with you.

The first is centering rituals: daily self-appraisal, goal-setting, and meditation/prayer that help keep one’s “eyes on the prize” and help maintain personal integrity. Such rituals also keep one focused on the primacy of personal recovery by reminding us that recovery advocacy is not a program of personal recovery.

The second is mirroring rituals: regular communion with mentors and kindred spirits who share our passion for this work.

The third is acts of self-care: personal repair and replenishment, but this also includes care for one’s family and other primary relationships. The best advice I have ever been given as an advocate is captured in the following statement: “*One must be careful when carrying light to the community to not leave one’s own home in darkness.*”

The fourth replenishment ritual is unpaid acts of service outside of our advocacy activities. These activities exercise our service muscles and connect us to kindred spirits outside the world of addiction recovery.

### **Closing**

I have had the great honor of serving as the historian of the new recovery advocacy movement since its earliest days. From the beginning, those of you on the front lines of this movement have been my heroes. In 2001, I challenged you in St. Paul to go make some history, and that’s precisely what you did. I sleep well knowing that the future of addiction recovery in America is in your hands.

**About the Author:** William White has worked as a volunteer consultant for Faces and Voices of Recovery since its inception and is author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* and *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*.