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A Lost Vision: Addiction Counseling as Community Organization

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Abstract.

Addiction counseling in the modern era has been practiced as an essentially clinical activity, but this has not always been the case. There have been key points in the history of addiction treatment when the functions of community organization and social activism competed with, or complemented, this clinical orientation. The first section of this paper draws on nine episodes in this history to explore the relationship between addiction recovery and the addict's identification with, and participation in, a community of recovering addicts. The second section utilizes the work of John McKnight to explore how professionalized and institutionalized services can inadvertently undermine the development and vitality of indigenous community support systems. The third section outlines a series of recommendations that would shift the focus of addiction recovery from something that happens exclusively in the context of professionally-directed treatment to a process that unfolds within the larger community. It is argued that the professionalization (medicalization and psychologization) of addiction treatment needs to be balanced by a re-emphasis on recovery as a connection with indigenous resources and relationships beyond the self. The paper closes with a discussion of the potential pitfalls of this shift in focus from clinical technique to community resource mobilization.

Keywords. Community organization, social model, mutual aid, consumer involvement, history of treatment, role of addiction counselor.

We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.

-Sandra Bloom, Creating Sanctuary

I

The Lessons of History

There are several critical episodes in the history of addiction treatment and recovery in America that offer an opportunity to examine the ways in which personal recovery is nested within, or occurs independent of, a larger experience of connectedness to a recovering community.¹ Each of the following episodes provides a different perspective on the question of whether recovery is something that *emerges from within* the individual, something that *happens to* the individual within professionally-directed treatment, something that *is experienced in the context of the addict's identification and relationship with* a recovering community, or something that results from unique combinations of these experiences.²

1. Abstinence-based Cultural Revitalization Movements Alcohol-related problems rose in tandem with the physical and cultural assault upon Native American tribes during the 18th and 19th centuries. Three approaches typified tribal responses to these problems. First, there were individual solutions: Native medicines used to treat alcoholism, Christian conversion, and pledge signing initiations into Native American temperance societies. Second, there were environmental solutions. Native leaders-Little Turtle, Tecumseh, Sitting Bull, and Crazy Horse, to name just a few-voiced strong opposition to the use of alcohol as a tool of exploitation, advocated laws prohibiting the sale of alcohol to their tribes, and sometimes attacked and destroyed the supplies of predatory whiskey sellers (Lewis 1990; Apees 1833). A third approach framed the source and solution to alcohol-related problems in cultural terms.

Leaders of abstinence-based cultural revitalization movements (Wagomend, known as the Assinsink Prophet; Papoonan, a Unami Delaware; Kenekuk-The Kickapoo Prophet; the Delaware Prophet; and Handsome Lake), many in personal recovery from alcoholism, portrayed alcohol as a symbol of the worst of what happened when Native Peoples abandoned their own traditions and cultures for less noble ones (Waldman 1988; Francis 1996; Herring 1988; Custer 1918). Alcoholism was framed as a consequence of colonization and cultural dispossession, and abstinence was framed as an act of resistance and a step toward repossession of Native culture and identity. The later ritual use of peyote by some Native American alcoholics provides yet another example of a cultural framework of recovery from alcoholism. Here it was not the peyote experience alone that enhanced recovery from alcoholism but the Peyote Way-an ethical code that helped one live sacredly and soberly in relationship to family and tribal community (Albaugh and Anderson 1974).

Within Native American cultural revitalization movements, the healing of those addicted to alcohol occurred first through a renewed tribal community and then through personal fidelity to one's tribal traditions.³ An important principle undergirded these early abstinence-based movements: *personal sobriety and survival may be inseparable from the sobriety and survival of a larger community. The individual draws nourishment from the sobriety of the community just as the sobriety of the individual feeds the community. Addiction recovery for members of a besieged group is best framed within a message of hope for a people as well as the individual.*

2. Nineteenth Century Mutual Aid Societies Three major alcoholic mutual aid structures grew out of the 19th century temperance movement: the Washingtonians, the fraternal temperance societies, and the reform clubs (Maxwell 1950; Temple 1886; Ferris 1878).

The most vibrant and viable recovery movements are both visible and accessible to addicted members living within the wider community. Alcoholics and addicts are most attracted to appeals for participation that are free of moral condescension and which maximize the process of addict-to-addict identification. The Washingtonians actively recruited alcoholics from their own social network as well as on the streets and in the bars. When the Washingtonians stopped such recruitment and shifted from a closed (alcoholics only) to open meeting structure, class distinctions prevailed, the percentage of "hard cases" declined, and the focus on the reclamation of the confirmed drunkard was lost (Blumberg 1991). *Mutual aid societies lose their vitality when their members become disconnected from the people who most mirror their own pre-recovery histories.*

The Washingtonian experience-sharing meeting was able to elicit a sobriety decision (the act of signing the pledge), but did not provide a framework or a context for long term recovery.

The fraternal temperance societies and reform clubs sought to counter this failure by moving beyond the pledge decision to a focus on building a sober life in the community. By providing food, shelter, clothing, sober fellowship and help restoring the family, these support structures helped to re-integrate the alcoholic into the community. An important lesson learned in America's earliest alcoholic mutual aid societies was that *what works to initiate sobriety may be insufficient to sustain sobriety*.

Addiction mutual aid societies face risks at two extremes in their relationship to the wider community. When they move towards extreme isolation from the community, such societies risk becoming therapeutic cults dominated by and exploited by their charismatic leaders. When they interact too freely with the outside community, such societies risk being colonized by those with agendas other than helping the addict. The emotional power of the Washingtonians was used to re-energize the larger temperance movement, just as this power was being depleted by Washingtonian leaders who used their new status as reformed drunkards to pursue paid careers as temperance lecturers/missionaries (Blumberg 1991). *Recovery-focused service organizations can be hijacked and exploited for ideological, institutional, and personal gain*.

3. 19th Century Addiction Treatment The first formal treatment institutions in the country emerged in the 1860s and 1870s and represented quite different views on the relationship between recovery and community (Baumohl, Room 1987; White 1998).

Small inebriate homes grew out of temperance groups and mutual aid societies, and the boundary line between these homes and societies was virtually invisible. The homes provided food, shelter and mutual support while involvement in religious and temperance meetings worked their transformative influence. Brief, three- to four-week voluntary stays in such homes focused on morally strengthening the inebriate's pledge of abstinence and on helping the inebriate initiate a sobriety-based lifestyle within the wider community (MacKenzie 1875). Support groups-such as the Godwin Association of the Appleton Temporary Home-were organized within these homes to provide inmates and graduates weekly meetings for sober fellowship and opportunities for service to new members (*Twelfth...*1884).

The medically-oriented inebriate asylums saw the cure of addiction as something that occurred to the addict in the context of a prolonged (months if not years) process of physician-directed, legally-coerced institutional treatment. The inebriate asylums isolated the addict from the negative (and potentially positive) influences of the community and focused on the addict's detoxification and physical and psychological renewal. When mutual-benefit associations did rise within these institutions (such as the Ollopod Club of the New York State Inebriate Asylum), they were not defined by professional staff as an essential element of addiction recovery (Parton 1868).

The for-profit addiction cure institutes combined the brief treatment period of the inebriate home with the physical methods of treatment of the inebriate asylum. The most well-known of such cure franchises-the Keeley Institutes-supported the development of the Keeley Leagues, a mutual aid society of 30,000 former Keeley patients, but the Leagues disbanded in the late 1890s amid charges that Dr. Leslie Keeley was trying to turn the Leagues into an advertising medium for the Keeley cure (Barclay 1964; White 1998).

We see in the three styles above how *the leaders of treatment institutions can encourage the development and use of indigenous mutual aid societies, virtually ignore such mutual aid societies, or co-opt such societies to further their own interests*.

4. The Urban Mission Movement Jerry McAuley, an alcoholic ex-con who became a

born-again Christian, launched the urban mission movement in the United States when he opened the Water Street Mission in New York City in 1872. What this movement did for the alcoholic was provide a message of warm invitation (“Everyone welcome, especially drunkards!” boasted the weekly newspaper advertisements) and a message of hope (the potential for recovery through rebirth) (Bonner 1967). Both this invitation to fellowship and this promise of hope were couched in an offer of immediate services (food, shelter, clothing, work) that the suffering alcoholic desperately needed. Those who worked in these missions went into the streets and bars to find alcoholics in need and introduced these alcoholics to a larger Christian community. For the alienated and marginalized alcoholic, the urban mission provided a bridge from the physical and cultural world of Skid Row to the mainstream churches and wider community to which these churches were connected. The spark of alcoholism recovery was seen as originating in a highly personal conversion experience that could only be sustained by living in fellowship within a Christian community. The job of 19th century mission workers was threefold: to remove the barriers (hunger, homelessness, sickness) that stood between the alcoholic and God, to use themselves as instruments of the Holy Spirit to touch the heart of the alcoholic, and to link the newly reborn alcoholic to fellowship with a wider Christian community. *What the religious revivals, urban missions and religiously-sponsored inebriate colonies provide (at their best) is a milieu of hope and an invitation for the isolated addict to live in a community of shared experience and belief.*

5. Alcoholics Anonymous Five historical milestones collectively shaped the relationship between Alcoholics Anonymous (A.A.), professionally directed alcoholism treatment, and the wider community (Kurtz 1979). These milestones include:

- 1) A.A. co-founder Bill Wilson’s 1936 refusal of an offer of employment as a lay therapist at Towns Hospital. (The acceptance of this position could have led to a professionalization of AA and resulted in AA becoming merely an extension of the earlier lay therapy movement.)
- 2) The crystallization of the Twelve Steps in 1938. (The Steps provided a framework of long term recovery that placed responsibility for recovery, not in the hands of professionals, but in the hands of alcoholics living in relationship to a Higher Power and a community of recovering people.)
- 3) The decision in the early 1940s that AA would not have paid missionaries to carry its message and would not operate hospitals for the treatment of alcoholism. (This decision rendered support within AA mutual rather than professional, and emphasized that AA and professional treatment were different entities.)
- 4) The formulation of the Twelve Traditions in 1946. (The Traditions insulated AA from the diversions of outside political and religious issues, prohibited AA’s affiliation with outside causes and organizations, and protected alcoholic-to-alcoholic identification by restricting membership in AA to those who possessed “a desire to stop drinking.”)
- 5) The on-going definition of the boundary between AA and “treatment.” (This boundary, drawn through AA’s experience in its relationship to hospitals and alcoholic “retreats” and “farms,” defined AA not as a “treatment” for alcoholism but as a way of living within a spiritual community [Harbaugh 1994, 1995].)

AA, by instinct and circumstance, forged solutions to the problems that had mortally wounded its predecessors: How to construct a framework of mutually-supported long term recovery while protecting the organization from external colonization and the foibles of its own

leaders and members. AA placed itself and the recovery process squarely within the fabric of community life but progressively delineated itself from professionally-directed alcoholism treatment (by admonitions against use of AA language within addiction treatment, e.g., “Twelfth Step House,” “AA Counselor”). AA and its Twelve Step children (Narcotics Anonymous, Cocaine Anonymous, ...) avoided the problem that had long-plagued institutional addiction treatment: the transfer of learning from the environment of the treatment center to the home environment of the person being treated (Patrick 1965; Stone 1997). No transfer was needed: *Twelve Step recovery, rather than being linked to a treatment institution, became imbedded within the community itself.*

6. The Early Industrial Alcoholism Programs Occupational alcoholism programs, the forerunners of today’s employee assistance programs, began to flourish in the 1940s when sober and grateful AA members working inside various companies began reaching out to their fellow alcoholic workers. Initially, these AA members provided support and counsel on an informal basis while continuing to work full time in their regular job assignments. Then AA members were re-assigned to full or part time roles in which their exclusive responsibility was to counsel alcoholic employees. This transition brought a new job title (occupational alcoholism counselor) and specialized training. When occupational alcoholism programs were later redefined as “broadbrush” employee assistance programs (EAPs), the former occupational alcoholism counselor was forced to acquire academic credentials and certification or be replaced by traditionally trained professional helpers. The “Drug Free Workplace” movement of the 1980s further shifted the focus of many EAPs from one of helping drug-impaired employees to one of detecting, controlling and extruding drug-using employees—a move that led many workers to view these former indigenous helpers as behavioral police. More recently, those working in employee assistance services have been moved outside the companies as a result of the trend toward company outsourcing of employee assistance services. As a consequence, these services are now provided by people who are not part of the internal web of relationships inside the organization and who often have weak or even non-existent ties to the local community. At the same time, the focus of EAPs further shifted from a focus on enhancing the recovery of impaired employees to one of aggressively managing the financial costs of such impairment (Bickerton 1990; White 1999). *Social movements organized by and for addicts are often diverted from this mission by the forces of professionalization and industrialization. Addiction recovery is enhanced when encased within a commitment to singularity of purpose and when the source of recovery is placed within the addict’s natural environment.* In the face of this changing character of EAPs, unions are again organizing their own counseling programs with a returned emphasis on salvaging those members impacted by alcohol and other drug addictions. *When professional structures of care collapse or lose their responsiveness to the needs of the addicted and their families, new indigenous structures eventually rise to fill this void of unmet need.*

7. The Implosion of Synanon Only a few times in American history has a totally new approach emerged for the treatment of narcotic addiction, but such was the case in 1958 when Synanon rose as the first ex-addict directed therapeutic community. Synanon created an alternative, closed community within which the addict was isolated, broken down, and then habilitated in a process that sought the fundamental reconstruction of the addict’s character. Widely acclaimed in the 1960s, Synanon became the model for virtually hundreds of therapeutic communities and residential treatment programs. But in the 1970s, Synanon abandoned its goal of rehabilitating and returning addicts to the community and took on the tenor of a militaristic religious cult. All but the most loyal of Synanon’s members were driven out of this community

and Synanon's founder and leader, Charles Dederich, was criminally indicted for an incident in which a live rattlesnake (with the rattles removed) was placed in the mailbox of a lawyer that had just won a suit against Synanon. In spite of its positive contributions to the evolution of addiction treatment, Synanon today stands as a morality tale about the abuses of power and breaches of ethics and law that can emerge when an historically stigmatized group isolates itself from the larger community and places itself under the control of a charismatic leader and his or her inner circle (Yablonsky 1965; Mitchell, Mitchell, Ofshe 1980).

Synanon also provides a powerful lesson about the relationship between recovery and community. The experience of Synanon and the second-generation therapeutic communities that followed suggest several crucial principles. *Institutions whose founding goal is to rehabilitate and return addicts to the community often end up further isolating addicts from the community. Recovery doesn't occur inside an office or an institution; it occurs within the larger context of life within a community. It must be anchored within the family, extended family, neighborhood and community institutions. The more complete and enduring a client's isolation from this natural web of relationships during his or her treatment, the greater the difficulty in transferring institutional learning to post-institutional life in the community.*

8. Grassroots Organizations to Formal Organizations During the 1950s and 1960s, several types of grassroots organizations were founded to address growing concerns about juvenile drug use and addiction. Those in the 1950s grew out of alarm over rising juvenile narcotic addiction and were typified by such programs as St. Mark's Clinic in Chicago and the East Harlem Protestant Parish's Exodus House in New York City. These religiously-sponsored, neighborhood-focused programs constitute the modern beginning of community-based addiction treatment. In the 1960s and early 1970s, the same youth culture that celebrated marijuana, and to a lesser extent, LSD, spawned a whole genre of drug-related service institutions: crisis lines, "Acid Rescue" teams, street drug analysis programs, free health clinics, and walk-in counseling programs. Counterculture agencies were organized by members of this culture to provide support to their peers. There were also a wide variety of programs that emerged from the larger community to respond to youthful polydrug use. Most of these grass roots organizations of the 1950s and 1960s were eventually absorbed into formal prevention and treatment agencies following the infusion of federal treatment dollars in the 1970s, or they faded into obscurity and died. In this transition, there was a shift from caring for addicts by the community itself to passing this responsibility along to a new class of professionals and new institutions within the community. *Indigenous community organizations often change their essential character as they migrate toward the status of formal, professionalized service organizations. Addiction treatment institutions tend to emerge through the efforts of grass roots movements and then become divorced from such movements and the wider community as they mature. Services that emerge out of a "we" position often evolve toward services provided by "us" to "them."*

9. The Early Professionalization of Addiction Counseling Before passage of the Hughes Act in 1970 and the establishment of the National Institute on Alcohol Abuse and Alcoholism, some of the most innovative alcoholism initiatives at the federal level came out of the Office for Economic Opportunity's (OEO) Alcoholism Counseling and Recovery Program, under the leadership of Matt Rose (McGovern 1992). The earliest national effort to organize and professionalize alcoholism counselors occurred when Rose brought together leaders of the OEO alcoholism programs in Atlanta in 1972 to found the National Association of Alcoholism Counselors and Trainers. Robert Waymer of Georgia, one of the founding members describes the core idea behind this seminal event:

Our original idea was to have counselors train people in communities to deal with the growing alcoholism problem. The training we taught was not based on clinical skills; it was based on a community development model with emphasis on AA. (NAADAC... 1992)

OEO's involvement in poor communities, particularly poor African-American communities during the vibrant days of the civil rights movement, gave these programs both a grass roots orientation and an activist temperament. What the core of OEO alcoholism leadership brought to this initiative was a belief that: *"Helping systems had to be built on the needs of, and be ultimately controlled by, the alcoholics and their families (Renaud 1982)."* The grassroots programs funded by federal, state and local funds that sprang up in the 1950s, 1960s and early 1970s emerged from deep roots within their communities. Members of those communities-many themselves in recovery from or impacted by alcoholism-devoted years of effort before the first grants created formal local service organizations and the first paid alcoholism counselors. When voluntary efforts alone proved to be inadequate to the magnitude of local problems, there were inevitable calls for greater organization, greater skill, and greater financial resources. In this rising tide of professionalization and industrialization, voluntarism within the addiction problem arena declined and was replaced by an emerging class of paid helpers. *Grass roots movements that spawn treatment agencies tend to dissipate as the leaders and members of these movements are professionalized or extruded during the rise of formal service organizations.*

The Present: A Field In Search of its Soul

It would not be an overstatement to suggest that the field of addiction treatment is in a state of crisis as the 21st century opens. Most define that crisis in terms of an aggressive system of managed behavioral health care that for the past decade has altered the availability and character of addiction treatment in both the private and public sectors. Others depict this crisis in terms of the cultural demedicalization and restigmatization that has moved large numbers of alcoholics and addicts from hospitals and treatment centers to jails and prisons during the 1980s and 1990s. But there is another much more fundamental crisis that is revealed in listening to the words of addiction counselors across the country.

Tenured addiction counselors are suffering from increased disenchantment in their professional lives. They regularly lament that it is getting harder and harder to feel good about what they are doing. This deep dissatisfaction comes from a feeling that treatment institutions have become places where addicts are billable commodities more likely to be repeatedly processed than changed. There is a sense among "oldtimers" that something indefinable has been lost as the field has matured. Many are referring to the field's crisis as spiritual in nature-a crisis in values. There are suggestions that the field has become disconnected from its roots and even suggestions that the treatment field needs to conduct its own fearless and searching moral inventory. There is an emerging consensus that new clinical technologies can not make up for a lost sense of mission and core values. Paramount among such dissatisfactions is the sense that *addiction treatment has become disconnected from its historical roots, detached from the larger and more enduring process of addiction recovery, and divorced from the grass roots communities out of which it was born.*

This is not the first time such sentiment has emerged among professional helpers.

Lubove and Specht and Courtney have separately described similar processes through which social work shifted from a focus on resource mobilization in their clients' environments to engaging clients in psychotherapy (Lubove 1965; Specht, Courtney 1994). The shift from psycho-social casework to psychotherapy marked a relocation of service delivery-from the community to the consulting room-and a shift in the target of such services from the environment of the client to the unique developmental history and mental/emotional processes of the client. In response to this change, there were charges that social work, in its search for professional status, had forsaken social and political action for the mastery of clinical technique and charges that social workers were selling out the community for the higher salaries of the consulting room. This shift from the social to the clinical has for addiction therapists, like the psychiatrists, psychologists and social workers before them, led to a pre-occupation not only with their client's emotional life but also their own. The new addiction counselors of the 1970s and 1980s discovered their own emotional life as a rewarding area of study and as a potential diversion from their focus on the needs of the client. Addiction counseling, perhaps under the impact of the larger culture in which it is imbedded, shifted to a focus on the "self" (Lasch 1978; Bellah 1985). What got lost in this shift were the functions of community education, social action, resource development, resource mobilization, and resource linkage: in short, the field's role as an active agent in enhancing the healing power of the community. The current preoccupation with "case management" in addiction treatment is in many ways a piecemeal attempt to compensate for this loss.

II

Community, Treatment, and Recovery

Ultimately, it is the community that cures....To cure the wounded, one need only return them to their community or construct a new one. (Philip Rieff 1987)

We can see from these historical vignettes many variations on the role of community in addiction recovery. Addiction is often depicted as a disorder that has biological, psychological, social, cultural, and spiritual dimensions, but individual addiction treatment therapists/agencies and addiction mutual aid societies differ widely in their emphasis of one element over the others.

This emphasis also evolves cyclically; so-called "new" approaches in the addiction arena often have a musty quality to them. And so it will be with the discussion that follows. What follows is as much a call to recapture roots as it is a call for bold innovation.

In 1995, John McKnight wrote a book, *The Careless Society: Community and its Counterfeits*, with a most provocative premise. McKnight suggested that the proliferation of helping agencies and paid helpers inadvertently undermined the natural web of supportive relationships provided by families, extended families, neighborhoods, churches, labor unions, other voluntary associations and whole communities. McKnight concluded that as a country we suffer not from a lack of professionally-directed service agencies but from a lack of community. (pp170-172). He suggests that we need to "distinguish between services that lead people out of community and into dependency and those activities that support people in community life" (p.123). An example from the addiction/recovery arena illustrates McKnight's point. To the extent that the interventions of addiction counselors have replaced Twelfth Step calls, the "culture of recovery" has been weakened rather than strengthened (White 1990, 1996).

McKnight proposes a new role, that of the "community guide," whose function is to

move clients, not toward enmeshment with professional helpers and their institutions, but toward deeper involvement in the problem-solving and healing resources within the community itself. The goal of the guide is to “reduce dependence on human services by increasing interdependence in community life...”(p. 122).” McKnight contends that equal relationships of shared experience are infinitely superior and more sustainable than relationships that are hierarchical, professionalized, and commercialized (p. 119).

McKnight’s analysis provides a fresh way to view the earlier reviewed milestones in the history of addiction treatment and recovery. Since the days of the inebriate homes and asylums, there has been disagreement about whether treatment of addiction requires moving addicts deeper into the life of a community or isolating them from the community. There are deep biases toward sequestration of the addict: the inebriate asylums, the federal narcotics farms, Synanon, and many of today’s residential programs and religiously-sponsored alcoholic retreats. Treatment professionals have long viewed the client’s natural environment as an enemy rather than an ally in the recovery process. And yet there are other threads in this history that have invited the addict into the experience of community and sustained that experience in the community: the inebriate homes, the urban missions, and mutual aid societies from the fraternal temperance societies and reform clubs to AA and NA and the new societies that have followed.

We are in an era of potentially landmark clinically advances: psychopharmacological adjuncts that promise to help quiet the siren call of the addict’s drug of choice (Kranzler, et.al., 1999); sophisticated models of understanding the stages of addiction recovery (Prochaska, DiClemente 1986; Prochaska, Norcross, DiClemente 1994); improved strategies and techniques of client engagement (Miller, Page 1991; Miller, Rollnick 1991); empirically-validated and manual-guided individual, group and family therapies (Carroll, Nuro 1996); and research-based relapse prevention tools (Marlatt, Gordon 1985). The era of professionalized addiction treatment (1970-2000) has been built more on the promise of medical, pharmacological and psychological treatments than on the role the wider social milieu can play in initiating and sustaining recovery from addiction. The following discussion is a call for the rediscovery of the power of community in the recovery process. It is not a call for the abandonment of medical and psychological interventions, but a call to for balance between medical, psychological and socio-cultural approaches to addiction treatment and recovery. It is most importantly a call to shift the delivery of these interventions into the natural environment of the client.

Addiction treatment must always adapt to the evolving context in which it finds itself. Such redefinition may push treatment toward the experience of retreat and sanctuary in one period and toward the experience of deep involvement in the community in another. I would suggest that the focus of addiction counseling today should not be on addiction recovery-that process occurs for most people through maturation, an accumulation of consequences, developmental windows of opportunity for transformative or evolutionary change, and through involvement with other recovering people within the larger community. The focus of addiction counseling today should instead be on eliminating the barriers that keep people from being able to utilize these natural experiences and resources. Our interventions need to shift from an almost exclusive focus on intervening in the addict’s cells, thoughts and feelings to surrounding and involving the addict in a recovering community.

The recognition of limitation-according to Ernest Kurtz the very foundation of Twelfth Step recovery (Kurtz 1979; Kurtz, Ketcham 1992)-is also an essential foundation for addiction counselors and addiction treatment agencies. Such a recognition is crucial in defining the

boundaries of what treatment can and cannot do and in understanding why treatment agencies must move into the community to compensate for this limitation. To the extent that a treatment program expends resources in support of this community-based culture of recovery, they address dimensions of recovery that cannot be addressed directly within the treatment environment. To the extent that addiction treatment professionals attempt take the place of these natural resources, they are practicing beyond the boundaries of their professional training and usurping, and potentially weakening, structures in the community that are better equipped to perform this task.

Addiction counselors need to help create and support voluntary communities of recovering people and enhance the involvement of others who are willing to enter into sobriety-based fellowship with this community. Our focus should be not on what professionalized services we can offer members of this community, but on how we can support the development of resources within this community that diminishes its members' needs for professionalized services. In short, the goal is to replace relationships that are transient, hierarchical, and professionalized with relationships that are enduring, equal, and reciprocal. For fear of being misunderstood, let me say again that I am not calling for the destruction of professionally-directed addiction treatment services. (I have spent more than 30 years helping develop such services.) But I am calling for a redefinition of these services. In many communities, professionally-directed addiction treatment needs to be reduced to its most critical dimensions; it needs to become smaller, not larger. What does need to become larger is the web of support in the community itself for recovering addicts and their families. Treatment should not be the first line of response for addiction but a safety net for those individuals facing special problems in their ability to find and utilize these larger and more natural support networks. The job of treatment is to do what the community at any given moment cannot do. If one believes that recovery involves a transcendence of self-an experience of relationships and resources beyond the self-then the most legitimate role for addiction treatment providers is that of removing barriers that stand in the way of connection to such resources and helping enhance the variety and viability of such resources.

What does a treatment institution do when there are few indigenous recovery support systems in their community and they face a growing number of their clients who are isolated from families and disenfranchised from the mainstream community? The treatment center's role in such circumstances is to help build and mobilize resources within the community that such clients can rely upon. Its role is to create space within the larger community where such resources can grow, sew seeds in that space, and to nurture the emerging indigenous resources until they can flourish on their own. Under some circumstances, a treatment institution will have to take on the roles of surrogate family, surrogate extended family, and compassionate community in the lives of their most alienated clients until more natural and enduring resources can be developed. Both barriers to and incentives for recovery exist in the community space surrounding the client and it is that space that must become the arena of activity for the addiction treatment professional.

Recovery Community

When we hear the word "community," we tend to think of a city or neighborhood. Community can imply a geographical boundary, but it can also imply the boundary of what Ferdinand Toennies (Toennies, 1957) has called a "reciprocal, binding sentiment," e.g., the

“African American community,” the “faith community.” Communities of experience are generated and sustained by shared history, hopes, beliefs, language, rituals, and folkways. There is in the experience of community a sense of identity—a “we-ness,” a sense that we are with “our own.” Here one’s estrangement—the experience of *self detached* from others different than me—turns into the experience of *self among* others like me.

There is in the concept of community a sense of linkage, belonging, and acceptance and a connection to place. There is a sense of *being at home*—of being at the one place where one’s absence would be missed. With communities traditionally defined by kinship, residence and workplace dissipating, a new kind of community—a community of recovery—has emerged that can offer sanctuary and healing to those who have been stigmatized and marginalized by their addiction careers. This “community” is one defined not by neighborhood but by shared experience, shared identity, shared need, shared hope, and shared support.

When we speak of “recovery community,” these qualities take on added significance because of the shared wounds its members bring to their membership in this community. It is here that those who have never experienced sanctuary often discover a place where they feel physically and psychologically safe for the first time. Here one is accepted not in spite of one’s imperfectness but because of the very nature of that imperfectness. It is this shared “torn-to-pieces-hood” (as William James called it) that turns “people who normally would not mix” into a “fellowship” (Perry 1935, p.679; *Alcoholics ...* 1955, p.17). It is here that, in discovering one’s self in the stories of others, people discover themselves and a “narrative community” whose members not only exchange their stories but possess a “shared story.” Within such a community, one can find a deep sense of fit—a sense of finally discovering and connecting to the whole of which one is a part. The recovery community is a place where shared pain and hope can be woven by its members into life-saving stories whose mutual exchange is more akin to communion than communication (Kurtz 1997a; Kurtz 1997b). This sanctuary of the estranged fills spiritual as well as physical space. It is a place of refuge, refreshment and renewal. It is a place that defies commercialization—a place whose most important assets are not for sale.

The Varieties of Community Experience

To speak of the “recovery community” today requires an understanding that this community actually constitutes an ever-growing variety of sobriety-based support structures and styles of recovery. First, there is not only the growth and expansion of AA, NA and other Twelve Step recovery programs but the ever-expanding varieties of AA/NA experience (Kurtz, 1999). There are what might be called Eleventh Step groups—groups such as the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS)—that are used as adjuncts to AA. There are the abstinence-based alternatives to Twelve Step programs that include Women for Sobriety, Secular Organization for Sobriety, LifeRing Secular Recovery, and Rational Recovery. There are groups like Alcoholics Victorious, Alcoholics for Christ, Mountain Movers, High Ground, and an ever-growing number and variety of other religiously-sponsored addiction recovery support groups. There are cultural pathways of recovery ranging from Afrocentric frameworks (Williams 1992) to Native American frameworks—the Peyote Way, the Red Road, Circles of Recovery, and Firestarters (Bordewich 1996; *A Report...* 1998). There are a growing number of moderation-based support structures (Moderation Management, DrinkWise, SMART) for those who wish to temper their drinking but who are not addicted to alcohol. There are a large number of people attempting “solo recovery,” some aided by manuals that promise a self-engineered resolution of alcohol and other drug problems without the requirement for treatment or

support group affiliation. And nearly all of these resources can be reached via the Internet, creating a virtual recovering community that no longer has geographical boundaries.

How do we make sense of such diverse structures and styles of recovery in the community and their relationship to professionally directed addiction treatment? Four key understandings could guide this relationship:

1. There are success stories to be found in almost all advocated approaches to addiction recovery, including some that probably reflect little more than a well-timed placebo effect.
2. If we assume that alcoholics and addicts are not an homogenous population, then it follows that no one approach will meet the needs of all addicts and that any particular approach will vary in its degree of success with different clinical subpopulations.
3. If we agree that addiction is a chronic disease (or “condition”) characterized in the lives of many addicted people by reoccurring episodes of remission and relapse, then we have to consider that such individuals may require different types of interventions and support structures at different stages of their addiction/recovery careers.
4. We are likely to discover that, for some addicts, the most successful approach to treatment/recovery is one that involves serial experiments in sobriety, sobriety monitoring, early re-intervention and combinations (accumulated effects) of interventions and support structures over time. (The operative motto-”different strokes for different folks”-has long marked the most successful and clinically-nuanced addiction treatment programs.)

These understandings constitute a foundation from which a counselor can both help organize the community and “work the community” for the benefit of his or her clients. What we need to move toward within the arena of addiction treatment is the creation of the broadest possible menu of words, ideas, support structures, rituals, and experiences from which diverse clients may select those particular menu items that pull them toward positive change. Addicts have all kinds of coercive forces pushing them toward recovery; what we need are expanded forces of attraction that pull the addict into recovery. This latter force often occurs in the dynamic interaction between a support group, its evolving stew of conceptual and experiential ingredients and the addict.

How do we understand how various support structures incite change in some addicts and resistance to change in others? It is in the unique match between the ingredients of such groups and particular individuals that we find the transformative power of mutual aid. To have this effect, the elements of group culture must strike cords of resonance at both personal and cultural levels. Where resonance exists, these elements become the raw materials used by the addict to reconstruct a sobriety-enhancing life story. The elicitation of this resonance involves an almost electrical mutuality of fit. There is in this dynamic interaction as much a sense of having been chosen as there is a sense of choosing a particular framework of recovery. It is both a “you belong with us” connection between the group and the individual and a “this is where I belong” connection between the individual and the group. The job of the guide is to help expand the community menu of such resources, to warmly introduce each client to these resources, to help eliminate the obstacles that stand between the client and his or her involvement in such resources, and to then witness and validate the potential power of these special connections between individuals and indigenous groups. The emergence of “guides” or “recovery coaches” could re-capture the best of what has been lost in the professionalization of the role of the addiction counselor.

A Renewal Movement: Some Beginning Goals and Prescriptions

We have resources. Can we mobilize them?

(Selden Bacon, 1947)

The field of addiction treatment is in deep need of a process of renewal that allows it to get back in touch with its historical mission and values and redefine its service technologies. I believe the heart of that re-centering process will be a conceptual redefinition of where and how recovery occurs—a shift in focus from the institutional setting to the community setting. To achieve this redefinition of treatment, addiction treatment agencies will need to achieve six goals.

Knowledge Development The first goal is to expand the agency's knowledge of and application of the concept of "culture of recovery." We must recognize different styles and pathways of long term recovery. For most addicts, addiction and recovery occur and progress in relationship to addicted and recovered people. In addiction, and for some in early recovery, that progression involves an isolation from the larger community and an enmeshment in either a culture of addiction or a culture of recovery. Both cultures have their own language, values, symbols, career milestones, roles and rituals of daily living. We need to recognize and respect the variations in how addicts and those in addiction recovery relate to these cultures. There are acultural, bicultural and culturally enmeshed styles of addiction: addicts who sustain their addiction in isolation from other addicts, addicts who move in and out of the mainstream community and drug-saturated subcultures, and addicts whose whole lives are consumed within subterranean cultures of addiction. There are similarly acultural, bicultural and culturally enmeshed styles of recovery (White 1996).

Many treatment agencies have lost touch with local cultures of addiction and recovery. We have lost much in the transition from grass roots community organizations to behavioral health businesses. The practice of alcoholism counselors who are not in recovery attending open AA meetings and Al-Anon meetings, for example, seems to have virtually died out. The tentacles of our agencies that once reached deep into our communities have been replaced by paid specialists who venture into the community for public relations and marketing purposes. The beautiful buildings that many of our agencies have constructed have for too many of us become professional prisons that have diminished our interactions with the actively addicted and those in long term recovery. Too many agencies have become "closed incestuous systems" isolated professionally and socially from the wider community (White 1997). All of us—physicians and nurses, addiction counselors, researchers and teachers, supervisors and managers—need to leave our offices and rediscover the social ecology within which both addiction and recovery are nested within our communities. We need to be meeting with the service committees of local addiction mutual aid societies. We—those in recovery and those not in recovery—need to get to know the recovering community by attending (within the prescribed guidelines for participation) meetings and social events of such organizations. We need to be visiting with the leaders of religious and cultural revitalization movements in our communities. We need to break bread with those working within our local union counseling programs. Rather than waste our lives obsessing about managed care, we need to relearn the cultural terrain outside our agencies and help create spaces within our communities that can serve as sanctuaries and places of renewal for recovering addicts and their families. And most importantly, we must enter into relationship with these indigenous resources as students rather than as teachers.

Role Redefinition The second goal is to expand the definition of addiction treatment and addiction counseling to include and emphasize the functions of community organization and community development. I am proposing that the clinical dimensions of the role of addiction counseling be balanced with dimensions that focus on organizing sobriety-based support structures and then linking clients to such structures. This added function or new position would combine both the role of community organizer and what McKnight calls the “community guide.” The purpose of the organizer/guide is to help build enduring sobriety-based support structures that stand, not as time-limited, contractual services provided by an agency, but as an enduring part of the fabric of local community life. McKnight describes five characteristics of such roles/persons:

- They have a capacity to see possibilities and potentials where others see problems.
- They are themselves well-connected to what might be called the “communities within the community.”
- They can make things happen because they are trusted within these communities rather than because they have letters or titles linked to their name.
- They believe that the community as a whole is a “reservoir of hospitality” that needs only be tapped.
- They know that a client’s engagement with the community doesn’t begin until the guide whose with them disengages (McKnight 1995, pp120-122).

The guide, recognizing and celebrating the enormous variety in recovery styles, simply serves as a source of introduction and encouragement for continued experimentation until the client finds a suitable pathway of long-term recovery (Borkman 1997).⁴

One very concrete way that an addiction treatment agency could begin this process is to experiment with:

- adding community organization functions into existing addiction counselor role responsibilities,
- seeking financial support to hire community organization specialists, and
- providing training to staff to enhance their skills to perform community organization/guide functions.

Community Involvement The third goal is to increase the agency’s involvement in the community. The first step in achieving this goal is for a treatment institution to honestly evaluate it’s historical commitment and relationship to the community it serves. When the board and staff of Dawn Farm, a traditional long-term therapeutic community located in Ann Arbor, Michigan, conducted such a self-inventory, they were forced to make some bold admissions on their way to redefining their role in the community. The Board members and professional leaders of Dawn Farm called a large meeting of community stakeholders and acknowledged that with the best of intentions Dawn Farm had inadvertently implemented policies and procedures that had become barriers between the Farm and those it sought to serve as well as to the wider community. Following this courageous declaration, the leadership of Dawn Farm invited community stakeholders to participate in reshaping Dawn Farm’s involvement in, and responsiveness to, its local community.

Increasing community involvement can be achieved in a variety of ways: collaborating in multiagency models of service delivery, launching aggressive programs of outreach, moving satellite service offices into the community, experimenting with neighborhood-based service delivery, entering into partnership with such emerging resources as addiction ministries, and strengthening the agency’s relationship with indigenous sobriety-based support structures. This goal can involve

everything from carrying institutional services to the community to shifting the whole focus of recovery to the natural environments in which clients live. To achieve the latter, we need carefully constructed and rigorously evaluated experiments in moving the “therapeutic community” into the community. The question of “how do we get addicts to come into treatment at our agency?” needs to be reframed: “How can we move treatment (the professionally-guided initiation of recovery) from our agency into the community?” By creating seamless and flexible transitions between levels of care, we can move clients toward the least restrictive environments and into those environments that are closest to the natural supports in the community. Dawn Farm, in redefining its mission, formulated a simple principle to guide its selection of service activities: “Will this help our clients join the recovering community?” Taking such a position requires a fundamental redefinition of the relationship between an addiction treatment agency and the world outside itself.

Benjamin Bowser, in his excellent analysis of what it means for an addiction treatment program to be “community-based,” predicts a future shift from professionalized to indigenous recovery resources.

When the current generation of drug treatment programs declines far enough, we may very well witness the emergence of another generation of drug treatment initiatives which may not be so ready to compromise their missions for government funding. (Bowser 1998).

New generations of programs will boldly respond to service needs rather than passively accepting the limitations of various funding guidelines. These new programs are arising as indigenous institutions (neighborhood organizations, schools, churches, labor unions, cultural revitalization movements, recovery groups) respond to needs that they see not being addressed by mainstream addiction treatment providers. That new generation could also include existing treatment agencies who move forward by reconnecting with their founding missions.

Addiction treatment professionals need to be part of these rising movements not out of a position of professional arrogance but as fellow members within the local culture of recovery. The goal is not to colonize these indigenous initiatives by using this movement to get referrals for treatment, by pushing these indigenous movements toward professional models of care, or by manipulating these organizations into lobbying for enhanced funding for treatment. Instead, the goal is to support these churches and labor unions and neighborhood organizations in the development of ideas, metaphors, and rituals that can move people from addiction to recovery within the cultural context in which they live. We must serve these new support structures rather than lead them, co-opt them, or compete with them.

Consumer Involvement The fourth goal is to increase the community’s involvement in the agency. This can involve building a strong alumni association, creating a feedback loop between former/current service consumers and agency supervisors and managers, developing linkages to newly emerging recovery consumer alliances, or, most significantly, bringing recovering people and service consumers into policy-making positions on agency advisory and governing boards.

What addiction treatment will have to address in the 21st century that it has never had to deal within its history is a strong consumer movement that, like its mental health counterpart, will demand increased accountability and responsiveness (*Brief... 1998*). We must find meaningful venues of participation for consumers and eschew the current propensity to use consumer involvement manipulatively as a device to market treatment programs or to generate political support for political agendas related to treatment reimbursement policies. If

professionals fail to enter into legitimate partnership with the recovering community and fail to significantly involve consumers in decision-making regarding their own care, then the ownership of the problem of alcoholism and other addictions needs to be wrested from the professional and returned to the community itself.

Resource Development The fifth goal is to take an active role in the development and support of local sobriety-based support groups. Rather than lament the absence of such structures, treatment institutions need to create the physical and cultural space within which such movements can grow and nourish the seeds of such movements that arise within this space. This strategy involves reducing environmental obstacles to recovery while expanding resources and opportunities within the client's environment. This can be done by promoting no-cost, or low-cost transportation and child care to get people to support meetings and sober social activities, developing job banks and volunteer job-coaching programs, developing housing programs (drug free zones in public housing, recovery homes), entering into partnership with other sobriety-based organizations to help develop drug free recreational activities. Recovery-themed radio programs are appearing locally and through national syndication and Internet recovery resources are growing so prolifically as to render any directory of such resources instantly out-of-date. In Lubbock, Texas, the Texas Tech Center for Addiction Studies at Texas Tech University is involved in an "addicts-to-scholars" program through which private funds are used to provide scholarships to recovering addicts to attend college (White, 2001). Treatment programs need to both stimulate such activity and reach out into partnership with such indigenous community efforts. When White Bison, Inc. of Colorado Springs, Colorado trains Firestarters-persons in recovery-who agree to facilitate Circles of Recovery in their tribal communities for three years, the focus of recovery shifts from a treatment institution to the community itself (*Brief...1998*). Treatment institutions have for more than 140 years served as sober sanctuaries- places for personal, social and spiritual renewal, but some have also served as a hub of numerous activities that reach out into the community to extend and nourish the culture of recovery. The motifs that should guide our own work in this latter area are:

- stewardship (Is this the best possible use of these resources?),
- simplicity (Is this the least amount of organization required to achieve this goal?),
- transferability (Can this function be transferred from the agency to the community in a reasonable period of time?), and
- sustainability (If other elements in the local culture of recovery cannot sustain this function, is this something that the agency will be able to sustain over time as one of its contributions to the culture of recovery?)

There are brief developmental windows of opportunity for change that open in the life of every addict, and, in the midst of such a window, one's life can be forever changed or a rare opportunity missed-the difference for some between recovery and death. Addicts "hit bottom" many times and often continue their self-destruction. Pain in the absence of hope will not incite a recovery process. Our goal is to assure the presence of personally and culturally meaningful resources (hope) when those windows of opportunity briefly open.

Identity Reconstruction The sixth goal is to redefine the implications of this new agency-community partnership on everything from the agency's mission, its core values, its primary service modalities, its role definitions for paid and volunteer workers, and its ethical standards governing relationships between staff and service consumers. To focus on barriers to recovery rather than recovery itself requires a reframing of traditional clinical roles, but this broader focus continues to call for the use of new breakthroughs in clinical technology to aid the

client. Adding community organization and community advocacy does, however, mark a dramatic change in the current role definition of the addiction counselor—a change that calls upon the counselor-like the Native American leaders of 19th century abstinence-based cultural revitalization movements—to confront forces in the community/culture that promote excessive alcohol, tobacco and other drug use.

Potential Pitfalls

The shift in focus advocated in this paper is not without its pitfalls.

1. *Skill Demands* The knowledge and skill requirements of the community organizer/guide are not part of the current preparation of addiction counselors nor may some addiction counselors be characterologically suited to take on these functions. Any shift toward expanding the functions of the addiction counselor would have to be reflected in changes in the content of addiction counselor training programs as well as national and state addiction counselor certification programs.

2. *Funding* Most reimbursement mechanisms for addiction treatment do not pay for community organization and advocacy. While some publicly funded agencies may be able to embrace such activities within the rubric of outreach, case management, early intervention, or primary prevention; funding guidelines will continue to narrowly define addiction treatment. The agency today seeking to become truly community-based must swim against the powerful current of these funding strictures. I think the trend will be for agencies to respond to the criticism inherent in this article by placing these functions within a specialty role. Such a move would mark not a positive indication of organizational change, but one of the most frequent strategies used by organizations to avoid change. At a practical level, I believe the desired strategy is to begin integrating resource development, resource mobilization and client advocacy functions within the rubric of case management and counseling and to seek additional reimbursement for these newly expanded functions. The potential role of community resource mobilization in improving clinical care outcomes will need to be rigorously evaluated before these activities are compensated within existing service reimbursement systems.

3. *The Limits of Community Support* The approach called for in this paper is applicable to a wide spectrum of human problems, but its proposed solutions all hinge on whether there is a reservoir of support available within local communities. There is little doubt that the traditional safety nets of nuclear and extended family, value-homogenous neighborhoods, stable occupational networks, and other social institutions (schools, churches, labor unions, local civic groups) are weakening. While one could argue that we need an ever-growing professional infrastructure to compensate for this loss of natural supports, I would argue with McKnight that proliferation of the former could inadvertently speed the demise of the latter. But tapping indigenous resources and spiritual and healing traditions within a community is not a panacea for addiction recovery (Brady 1995). There are communities that lack much of the natural supports idealized in this paper. In such communities, such resources will need to be rebuilt before they can perform their healing functions. We need to extend the medical models and even social model programs farther into the heart of our communities (Borkman et al. 1998)

4. *Resistance and Conflict* The expansion of the counselor role will provoke resistance among counselors for whom this transition will be difficult and who will likely interpret this expansion as an implied attack on the value of therapy in the treatment of addiction. Some counselors could feel a loss of status and prestige in the diminished clinical emphasis suggested in this paper. Social activism could also bring agencies into conflict with other community

institutions regarding such environmental factors as poverty, racism, zealous and targeted alcohol marketing campaigns or the oversaturation of alcohol sales outlets. There is also a risk that focusing on environmental factors that contribute to addiction could divert focus from service to the treatment/recovery needs of individual addicts. This very process happened to many of the 19th century mutual aid societies. Community-oriented activities will need to be monitored to assure that they stay client-focused.

5. *Charisma* The function of community organization attracts charismatic leaders whose character foibles can, rather than moving the organization into the community, create organizations that progressively isolate themselves and move into adversarial relationships with the community. These leader-dominated, cult-like systems often drift toward ideological extremism and eventually implode amidst charges of internal abuses of power and breaches in ethical and legal conduct. At its best, the heightened community-orientation advocated in this paper should help flatten the hierarchies of treatment organization, but the potential long term consequences of the charismatic leadership characteristic of such models requires close monitoring.

6. *Ethical Quandaries* The new role functions of the community organizer/guide force the counselor to shed the safety of the office and the execution of highly codified clinical functions. As the newly defined counselor/organizer/guide moves into the community, he or she does so without clear ethical and boundary definitions. Traditional standards which safeguard the therapeutic relationship often smack of emotional disregard and professional elitism when moved into the community and into different cultural settings. Professional standards that discourage/prohibit counselor self-disclosure (particularly self-disclosure of the therapist's own recovery status) and prohibit involvement in any type of dual relationships may work well in the office but not in the arena of community outreach and community organization. New standards will have to emerge and evolve to guide these expanded functions, and these standards will need to simultaneously protect clients and community members, individual workers, and addiction treatment agencies. The community guide will need to find middle ground between the potentially detached impersonality of the therapeutic relationship and the complete absence of boundaries that originally created a call for increased professionalism and ethical standards.

7. *De-professionalization* There is a danger that professionals could become so infatuated with indigenous cultures of recovery that they abandon medical, pharmacological, and psychological interventions that could be of great benefit to some addicts (Van Dusen, Sherman 1974). There is also some danger that professionals could use this approach as an escape from the demands to develop and sustain traditional technical competencies in addiction counseling.

8. *Care versus Control* The most painful aspect of this role transition may be a forced examination of the difference between the professional support offered in addiction counseling and the more natural support that clients can experience in the wider community. Any relationship of unequal power, any relationship in which one party is professionally pledged to serve the other, is a relationship that in its essence involves as much (or more) control as care. The history we have reviewed suggests that addiction recovery is best nurtured within a network of mutually caring and enduring relationships in which mutual vulnerability, reciprocity, and collective strength, not fiduciary responsibility of one party for another, is the primary bond of the relationship. That is precisely what traditional addiction treatment cannot provide. To experience care without control, one must move out of the professional arena and enter the natural web of support that exists within communities. This realization is not an easy one for those of us who have dedicated our lives to the profession of addiction counseling.

9. *Potential Iatrogenic Effects* Misguided efforts at community organization could undermine

the very indigenous supports they purport to build. Anything done *for* or *to* (as opposed to *with*) the recovery community is likely to undermine the growth and health of that community and replace it with structures and relationships that are hierarchical, professionalized, and eventually commercialized. The recovery movement itself will need to find a way to separate the healers from the hustlers who will be drawn to the energy of this movement. There will be problems with double-agency: people who step forward to speak on behalf of recovered people but whose words and deeds reveal the hidden institutional and financial interests that they represent. Misguided efforts at community organization could undermine the very indigenous supports they purport to build. What would help treatment institutions sustain their own integrity in this venture would be to create something analogous to the Twelve Traditions of AA—a set of principles that could guide the treatment institution’s relationship to its clients and the wider community.

Conclusion

This paper explores the evolving relationship, or lack of relationship, between addiction treatment, recovery, and experiences in the wider community. The author calls for a re-conceptualization of recovery as something that happens in the community rather than solely within the context of professionally-directed treatment. What is being proposed is a reconstruction of addiction counseling to claim its social activist and social movement roots—roots that were lost in the professionalization of the role of addiction counselor and the industrialization, commercialization, and regulation of addiction treatment. Addiction treatment needs to move from a self-absorbed bystander to full membership in the culture of recovery. In the next decade, many addiction treatment institutions will not only place themselves fully within this culture but also redefine their role in that culture. This newly defined role will focus on: 1) removing personal and environmental obstacles to recovery, 2) encouraging the diversity and viability of support structures within the culture of recovery, 3) educating clients and families about the addiction and recovery processes, 4) serving as “community guides” to link clients to support structures within the culture of recovery, 5) responding to the needs of clients with acultural styles of recovery, and 6) developing chronic disease management protocol for relapse-prone, multiple-problem clients and their families.

Where we will likely end up in all this is a position that will challenge two centuries of efforts to find THE cause of addiction and THE treatment for addiction. This position will simply posit that there are factors that inhibit and promote addiction that co-exist at different levels of intensity in the individual, in one's nuclear and extended family, in one's immediate ecosystem (peer associations, neighborhood, school, workplace, church), and in the larger macrosystem (state, country, continent, world). These factors combine with other demographic and clinical characteristics to create quite varied patterns of alcohol- and other drug-related problems. Prevention and intervention strategies that flow out of this model call for interventions at all levels of this ecosystem that simultaneously seek to increase inhibiting factors and decrease promoting factors. What has been missing and what is being called for in this paper is greater attention to this ecosystem in which both addiction and recovery are nested.

Agencies who in their earliest years defined themselves as "community-based" today are more likely to define themselves as businesses. To recapture that founding identity, agencies must find ways to rejoin their communities and discover the natural healing powers that lie within these communities. When universities became too isolated from the communities in which they were born, there were calls for these institutions to move back into the life of their communities-to become "universities without walls." What I am calling for is an analogous process of treatment and recovery without walls.

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NOTES

1. The use of the terms "recovering community" and "recovery community" in this paper does not mean to imply that this is a single, or homogenous community. This community is made up of a diverse patchwork of groups who often speak with conflicting voices about methods but who share a singular passion for helping convey a message of hope and support to addicts and their families.
2. These historical sketches are abstracted from (White 1998).
3. One of the most vivid examples of the healing power of tribal/community renewal can be found in the story of the Shuswap Indian community of Alkali Lake, British Columbia that was vividly portrayed in the film *The Honour of All*.
4. What I am calling for here is a synthesis between the traditional, expert-based "treatment planning" of medical model addiction treatment and the client-based "recovery planning" of social model programs. For a discussion of the distinctions between these models, see Borkman, T. (1997).

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