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Community Recovery

William L. White, M.A., Arthur C. Evans, Jr, Ph.D., and Roland Lamb, M.A.

Abstract

The concept of recovery within the addictions arena has most often been applied to the personal resolution of severe alcohol and other drug (AOD) problems. The emergence of the concept of family recovery suggests that social systems beyond the individual can be wounded by and experience recovery from the effects of AOD and related problems. This paper defines community recovery, posits a set of preliminary principles related to community recovery, presents a case study of community recovery, and outlines strategies used in the City of Philadelphia that are promoting processes of community recovery.

Introduction

Recovery is emerging as a central organizing concept for the transformation of addiction treatment and the broader arena of behavioral health care in the United States (Evans, 2007; Evans & Beigel, 2006; White, 2005, 2008a,b). Recent efforts to more precisely define recovery have emphasized reconstruction of relationship to community as a central element of the recovery experience. The Betty Ford Institute Consensus Panel (2007) characterized this reconstruction as “citizenship,” and the UK Drug Policy Commission Recovery Consensus Group (2008) described it as “participation in the rights, roles and responsibilities of society.” White (2007a), drawing on the broader conceptualization of recovery within Native American (Coyhis & White, 2006) and African American (White & Sanders, 2008) communities, subsequently depicted recovery as a healing process that could move beyond individuals and families to encompass whole communities, as graphically depicted below.

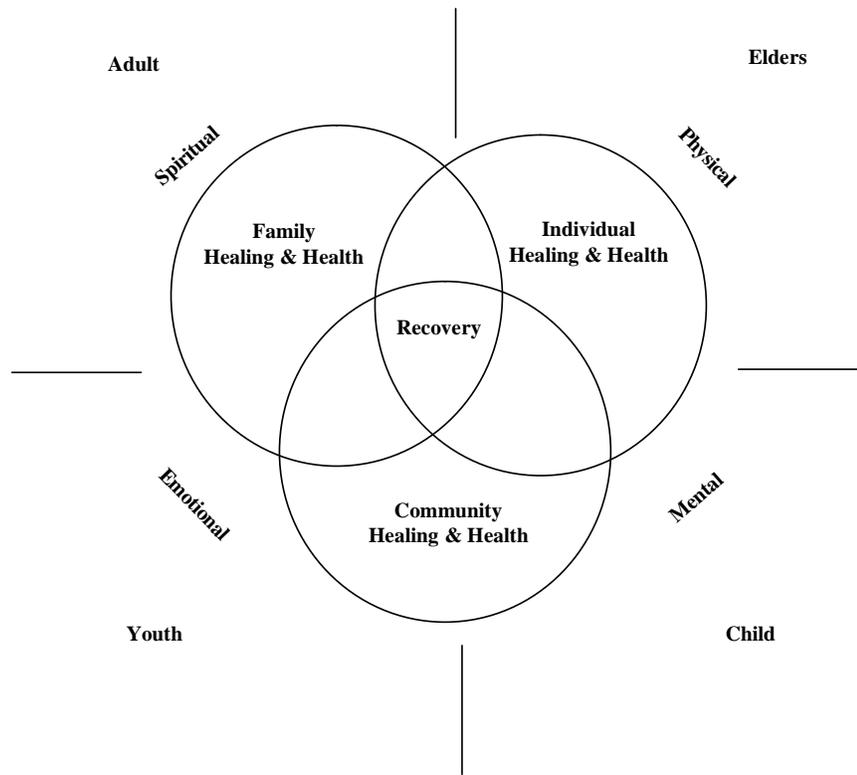


Figure 1: Recovery and the Life Cycle of the Individual, the Family, the Community
 Source: Charlene Belleau, Former Chief, Alkali Lake Band of Indians (White, 2007a, p. 237)

While a process of community recovery was suggested in this early article, the concept of community recovery was not defined or amplified. The purpose of this article is to draw on the authors' experience with a recovery-focused systems transformation process within the City of Philadelphia to define community recovery and outline some working principles related to community recovery.

The Ecology of AOD Problems

Communities as well as individuals and families can be wounded by severe and prolonged alcohol and other drug (AOD) problems. Widespread, excessive AOD problems erode sources of community resilience (e.g., strong families, close kinship networks, vibrant indigenous community institutions) and spawn collateral problems and conditions that further fuel AOD use and its escalating personal and community consequences. This self-perpetuating, accelerating cycle can be graphically depicted as follows.

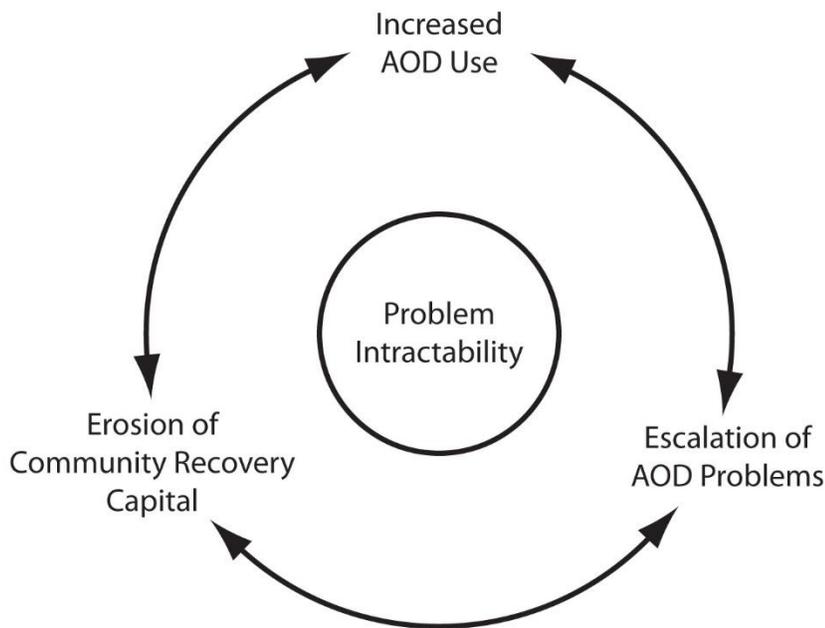


Figure 2: Problem Intractability and Personal/Community Demoralization

The etiology of AOD problems has in recent decades been portrayed within two organizing lenses, the first defining the problem as one of personal vulnerability (a genetically influenced disease process warranting medical treatment), and the second defining the problem as one of personal culpability (a moral or characterological problem warranting punishment and control). However, as the above figures suggest, there are contextual influences at a community level that profoundly influence the prevalence, course, and consequences of AOD problems. These contextual influences constitute the soil in which AOD problems flourish or are squelched at personal, family, and community levels. These influences also determine whether severe AOD problems are intractable or amenable to prevention, early intervention, treatment, and recovery support interventions.

Communities can experience three levels of strain that influence the prevalence of AOD problems. The first is the normal stress that all communities experience in response to internal and external changes. Most communities have the internal resources to respond to these stressors, and AOD problems in such communities are limited to a small percentage of community members who possess a particular vulnerability for AOD-related problems.

A second form of strain is distress—demands for community adaptation that exceed the collective coping capacity of community members. Such distress can occur in the face of natural disaster, loss of economic infrastructure, or extreme social disruption, cresting in a “tipping point” in the prevalence of personal/social problems. Under these circumstances, personal, family, and community deterioration unfolds and interacts synergistically to rapidly increase prevalence and severity of AOD problems. These problems and their connectors (e.g., family dissolution, child abuse/neglect, homelessness, crime, violence, infectious disease) become shrouded in an aura of intractability that spreads a contagion of frustration, hopelessness, apathy, and resignation or triggers aggression (shunning, scapegoating, punishment, community extrusion) aimed at, affected by, or viewed as the source of these problems.

A third form of community strain is that of historical trauma—a unique form of distress created by the physical or cultural assault on a people via attempted genocide or sustained colonization. Such trauma erodes indigenous sources of cultural and personal resilience and heightens vulnerability to a wide spectrum of personal and social problems. What is distinctive about historical trauma is the propensity for its effects to be transmitted intergenerationally over extremely prolonged periods of time (Brave Heart & DeBruyn, 1998). When historical trauma and contemporary distress align, communities, community institutions, neighborhoods, families, and individuals become particularly vulnerable to AOD problems (Brave Heart, 2003; Morgan, 1983). Over time, learned helplessness and hopelessness in the face of such problems can become part of the community culture absorbed across generations.

Alcohol and other drugs serve multiple functions in distressed and historically traumatized communities. They serve as a balm for emotional distress, an escape from feelings of powerlessness, and a trigger and excuse for the discharge of anger (Douglass, 1855). They serve as symbols of cultural protest (Lurie, 1974). They serve as the centerpieces of subcultures within which those most disconnected from mainstream community life find mutual support (White, 1996). They spawn underground economies and careers (Waldorf, 1973). They serve as instruments of financial exploitation by predatory industries, and they serve as tools of personal and cultural pacification (Douglass, 1855; Hacker, Collins, & Jacobson, 1987; Morgan, 1983).

Several propositions drawn from sociological and psychological studies can guide our shift in focus from the community context of AOD problems to community-level recovery processes. Among the most important of these propositions are the following:

- Weakened family, kinship network, neighborhood, and natural community ties create an environment in which personal and social problems flourish (Bellah, Madsen, Sullivan, et al., 1985).
- Weakened family, kinship network, neighborhood, and natural community ties diminish personal and collective capacities to respond to distress and trauma (Bloom, 1997).
- Resurging and new social structures (e.g., gangs, mutual aid groups, cell phone and internet-based social networking) are meeting support functions once met by traditional social institutions (e.g., churches, schools, workplaces, civic organizations) (White, 2002).
- The industrialization and commercialization of personal compassion (via ever-growing health and social services agencies) and social control (via ever-growing police, courts, correctional agencies, child protection agencies) may have inadvertently hastened the dissolution of family, kinship, neighborhood, and community ties (McKnight, 1995).
- “We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery” (Bloom, 1997, p. 117).

Strategies of community development and renewal (embraced here within the conceptual rubric of community recovery) can compliment and, in some cases, stand as an alternative to clinical models of intervention into AOD problems. There are pilots of community-level recovery resource development and mobilization from the 1960s and 1970s that could be refined and redeployed on a large scale to enhance the healing of individuals, families, and whole communities (Mulford, 1976, 1978; White, 2002, 2003). Such strategies reflect the Native American belief that “...the individual, family and community are not separate; they are one. To injure one is to injure all; to heal one is to heal all” (*Red Road to Wellbriety*, 2002, p. f).

Community Recovery: Definition and Principles

A neighborhood, community, or culture can be said to be in need of recovery when AOD-related problems reach a level of prevalence and severity that threatens collective health and functioning. In short, systems can become impaired by addiction and the broader arena of AOD problems, and they

can reach a level of such impairment that threatens their future vitality and existence. The need for recovery at a community level could be quantified using a broad spectrum of epidemiological data (e.g., AOD-linked data related to death, disability, disease, quality of family and neighborhood life, etc.) that is currently collected on a routine basis by a mix of federal, state, and local agencies.

Community recovery is a voluntary process through which a community uses the assertive resolution of AOD-related problems as a vehicle for collective healing, community renewal, and enhanced intergenerational resilience. Community recovery is more than the personal recovery of community members; it involves strengthening the connective tissue between those with and without such problems while restoring and sustaining the quality of community life.

Community recovery is *voluntary* in the sense that it involves a rising community consciousness (acknowledgement and clear definition of problems), community commitment, and community action. These three critical steps must rise from within the community and cannot be externally imposed. The stages of community recovery parallel the stages of personal and family recovery: 1) recovery priming (experiencing— suddenly or incrementally—a catalyst for change), 2) initiating a process of healing and renewal, 3) achieving sustained changes in community relationships, roles, rules, and rituals, and 4) enhancing the long-term health and quality of life within major community institutions and the community as a whole.

Community recovery is a *process* in the sense that it must unfold and be sustained in a prolonged if not permanent manner. It is not an event or one of a series of special projects. The factors that sustain community recovery are often different than the factors that initiate community recovery. The ultimate test of the community recovery process is not the mass recovery of one generation, but breaking intergenerational cycles of problem transmission and imbedding personal, family, and cultural resistance and resilience as an enduring intergenerational legacy within the deepest fabric of a community.

Community recovery is *assertive* in the sense that the diminishment of AOD and broader problems occurs as a result of concerted, collective action rather than a process of attritional drift (via the maturing, extrusion, or death of those community members with severe AOD problems).

The *resolution* of AOD-related problems reflects a broad spectrum of outcomes across neighborhoods, families, and individuals. These outcomes include the complete cessation of AOD use, reduction of AOD use to non-problematic levels, reduction of patterns of AOD use that pose the greatest threats to public health and safety, and the reduction of peripheral effects of AOD use on families and neighborhoods. The resolution aspect of recovery is measured by what is subtracted from family and community life.

Collective healing, renewal, and resilience are aspects of recovery measured by what is added to family and community life. These outcomes include the enhanced health of individuals; the repair of strained or severed relationships within the community; the renewal and rise of indigenous leaders; the enhanced health of key community institutions; intergenerational connectivity; and the enhanced resilience of individuals (particularly children, adolescents, and transition age youth), families, and neighborhoods.

The *prognosis for community recovery* is influenced by the ratio of problem prevalence, severity, and complexity to the level of community recovery capital. *Community recovery capital* encompasses the scope and quality of resources that can be mobilized to initiate and sustain a community recovery and revitalization process. People in personal/family recovery are an important source of recovery capital that can be mobilized to serve as recovery carriers in their daily interactions within the community. With rising recovery capital, push forces out of addiction (experienced and feared pain and consequences of AOD use) become balanced with pull forces for addiction recovery (attraction to the promises of recovery as exemplified in the lives of recovery carriers) (White, 2010).

There are *multiple pathways and styles of community recovery and renewal*. Successful strategies and tactics for community recovery and renewal must achieve a community/cultural fit. Each family/neighborhood/community must find personally and culturally meaningful metaphors that help them reconstruct a new recovery-based community identity (story) within which four questions are answered:

- Who and what were we before these problems peaked?
- What happened to us as a result of these problems?
- What sparked the recovery process?
- Who and what are we now and who and what are we becoming?

Sustainable community recovery engages multiple community institutions: government, business, and industry; civic and neighborhood organizations; health and social service agencies; educational institutions; the criminal justice system; religious institutions; sports and leisure institutions; and the arts community. The catalyst for community recovery can come from any one of these sectors, but the long-term prognosis for recovery and community renewal is enhanced when multiple sectors are involved.

Community recovery can be measured in terms of reduction of pathology, but is best measured in terms of long-term increases in recovery capital, e.g., increases in recovery prevalence, pro-recovery community policies, recovery support resources (mutual aid groups, recovery community organizations, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-identified sport and leisure activities, etc.).

Community recovery diminishes the necessity of personal and family recovery by lowering personal/family vulnerability and heightening personal/family resilience.

Community recovery elevates the prognosis for personal/family recovery by elevating external recovery capital and creating the physical, psychological, and cultural space where recovery can flourish.

A Brief Case Study in Community Recovery¹

No community response to alcohol problems has garnered more public and professional notice than that of the community of Alkali Lake, British Columbia. The Shuswap tribal community in Alkali Lake was so plagued with alcohol problems that surrounding communities referred to it as “Alcohol Lake.” The change began in 1971 when Phyllis and Andy Chelsea made a commitment to stop drinking and to confront the pervasive alcohol problems within their community. When Andy Chelsea was subsequently elected Chief of the Shuswap Tribe, he began promoting AA meetings, arresting bootleggers (including his own mother), confronting the drunkenness of public officials, and staging interventions to get community members into treatment. Tribal traditions were revitalized for both the adults and children of the community. Educational and job development programs were initiated for those in recovery. Over a period of ten years, this sustained effort reduced the prevalence of alcohol problems from nearly 100 percent of the tribe to less than 5 percent (Ben, 1991; Chelsea & Chelsea, 1985; Taylor, 1987). Community recovery is not a story with a beginning, middle, and end; it is an enduring process, and that process continues today in Alkali Lake (Haggerson, in press).

The story of the revitalization of Alakli Lake was captured in a documentary film, *The Honour of All*, directed by Canadian filmmaker Phil Lucas. The film inspired, and continues to inspire, sobriety-based cultural revitalization movements among indigenous peoples throughout the world (Ben, 1991). The proclamation of Chief Andy Chelsea that “the community is the treatment center” (quoted in Abbot, 1998) illustrates a collectivist, as opposed to individualistic, approach to the resolution of alcohol problems. As noted earlier, Native frameworks of recovery have always been, and continue to be, framed in terms of an inextricable link between hope for the individual and hope for a community and a people (*The Red Road to Wellbriety*, 2002). This theme is very evident in the contemporary Native American Wellbriety movement (Coyhis & White, 2006).

Notes from Philadelphia

¹ This case study is excerpted from Coyhis and White, 2006.

For the past five years, the authors have been involved with the Philadelphia Department of Behavioral Health’s efforts to transform Philadelphia’s network of behavioral health organizations into a “recovery-oriented system of care” (See Achara-Abrahams, Evans & Kenerson King, in press; Lamb, Evans & White, 2009; White, 2007b). As the “systems transformation” unfolded around the values of recovery, resilience, and self-determination, the vision of the “system” changed from a narrow focus on behavioral health service providers to transformation of the larger community. Through this process the inextricable link between personal, family, neighborhood, and community health became ever clearer, and we began to include the idea of community recovery within discussions of the systems transformation process. While concerted focus remained on enhanced recovery outcomes for individuals and families affected by behavioral health disorders, we regularly revisited this idea of community recovery as both a goal and method.

Through this history, several strategies emerged that promoted recovery at these multiple levels. Some of these methods that we now see as most linked to the goal of community recovery are illustrated in the following table.

Table 1: Philadelphia-Inspired Strategies to Promote Community Recovery

Goals	Strategies	Rationale
Listen and engage	Conducting ongoing focus groups, town meetings, and other listening forums; eliciting personal, family, and community stories in settings where people can share their personal and collective “experience, strength and hope.”	People in distressed communities need opportunities to share their struggles and experience being heard and understood. Healing can occur by seeing one’s personal story as part of a larger story—movement from an “I” story to a “We” story.
Open closed systems	Hosting meetings that mix treatment providers, allied professionals, individuals and family members in recovery, and grassroots community organizations; creating structured exercises in relationship-building to decrease polarization; facilitating (inreach and outreach) relationships with larger community.	Distress breeds isolation and “us versus them” thinking; closed systems open only via increased boundary transactions and cross-boundary relationships.
Forge or strengthen partnerships	Desiloization: experiments in co-location; pushing integrated solutions to entangled problems; creating win-win outcomes for collaboration; cross-funding initiatives.	Distressed communities suffer from problem synergy—each problem magnifying and rendering more intractable other related problems, e.g., addiction, crime, violence, homelessness, child abuse/neglect, jail overcrowding, spread of infectious diseases, etc.

Create amplified and synergistic effects through integrated and linked projects	Funding recovery support services within non-traditional settings; experimenting with co-location and multi-agency teams	Community recovery requires decreasing distance between the location of problems and the location of solution-based resources, e.g., building recovery capital within neighborhoods and communities.
Strengthen natural supports ²	Supporting grass roots efforts that provide support to the broader community; developing faith-based initiatives related to substance use prevention and persona/family recovery support; increasing collaboration between grassroots organizations and treatment providers through the development of community coalitions; seeding the development of activities that promote health and wellness through mini-grants to community based organizations	The most viable long-term recovery support is within relationships that are natural, non-hierarchical, non-professionalized, non-commercialized and sustained. The first-line of recovery support is the community; professional treatment is the safety net.
Promote tolerance, respect, and mutual support	Increasing contact between people affected by different challenges and between such individuals and members of the larger community; stigma committee strategy development.	Intolerance, stigma, and intergroup conflict are symptoms of community distress.
Inspire hope	Hosting recovery celebration events and recovery conferences; sponsoring recovery mural projects in the community; importing and developing charismatic speakers on addiction recovery.	Recovery initiation hinges on changing prevailing pessimism—elevating the idea that personal, family, and community recovery is possible and a growing reality. People who were once part of the problem can be transformed and mobilized as part of the solution.
Mobilize internal resources	Sponsoring storyteller training for people in recovery and families; identifying and engaging recovery community leaders; providing peer leadership training; increasing representation of recovering people within paid and volunteer roles; creating the Recovery Advisory Committee, Office of Addiction Services	Community recovery initiation is enhanced by mobilizing internal recovery capital. Community service is a vehicle of personal and community healing.

² We wish to acknowledge Dr. Ijeoma Achara for suggesting inclusion of natural supports in this table.

	Advisory Board, and multiple time-limited task forces.	
Mobilize external resources	Increasing procurement of federal and private grants to increase system resources (part of win-win strategy).	Community recovery initiation is enhanced by mobilizing external recovery capital.
Create a vision	Creating and disseminating Recovery Transformation Blueprint and Office of Addiction Services Strategic Plans.	Diminished attention span is a major indicator of community distress; community recovery requires a vision and vehicles to sustain commitment and focus: over-communicating and using every event to generate “legs” (systematic follow-up to achieve enduring effects).
Increase trust	Maintaining continuity of contact and commitment over time; assuring transparency in all decision-making; keeping promises; when wrong, promptly admitting it.	Exploitation and abandonment is the norm in distressed communities; community engagement requires a period of testing, trust building, and continuity of presence over time.
Over-communicate the vision, core ideas, and values	Providing centralized training of all stakeholders and recovery community to launch transformation process; Recovery Foundations Training for everyone in care system; using multiple media to convey vision and invite participation: papers and monographs, trainings, meetings, newsletters, newspapers, television, radio, video; involving indigenous leaders as message carriers.	Diversity of communication strategies must reflect knowledge of culturally-mediated learning styles. Repetition of communication over time and consistency of communication is needed to convey continuity of commitment to the community and key relationships within the continuity.
Provide Tools	Developing and disseminating science to practice papers, Tools for Transformation Series (checklists and promising practices), and Practice Guidelines.	Professional treatment should be the last, not the first, line of response to AOD problems. The front-line response to prevent and respond to these problems is the natural community itself.
Provide increased social space for recovery	Funding of Recovery Community Centers; providing people in recovery opportunities for community service; building recovery support into other community settings, schools, churches, businesses, arts, sports, etc.	Paying back (amends) and giving back (service) elevate the quality of long-term personal/family/community recovery.

Closing Reflections: Addiction Treatment and Community Recovery

As cultural commitment rose in the 1960s to take action on the country's growing alcohol and other drug problems, two models of intervention were proposed.

One model called for training consultants to mobilize local community resources to support long-term addiction recovery. The essential skills were those of community mobilization and development and brokering connections between individuals and families in need and indigenous recovery support resources. Those resources could include professional assistance in recovery initiation, but the emphasis was on support that was voluntary, reciprocal, enduring, and non-commercialized (Mulford, 1976, 1978; White, 2002, 2003). This approach mobilized community resources to support individual and family recovery but stopped short of conceptualizing a recovery process for the community as a whole.

A second approach, a medical model, relied on the development of specialized treatment facilities within which trained professionals would screen, assess, diagnose, and treat individuals and families impacted by severe alcohol and other drug problems. That approach, which laid the foundation for the modern addiction treatment industry, defined the source and solutions to addiction at the microsystem level (individual and family), provided clinical interventions restricted to the microsystem, and did not conceptualize the community as the "patient" (White, 2003).

To find the conceptualization of wounded community and recovery community, one must go to those working within historically disempowered groups, particularly those working in Native American and African American communities (See Williams, 1992). One of the most riveting metaphors emerging from the Native American Wellbriety movement is that of the Healing Forest (Coyhis & White, 2003). In this metaphor, the clinical treatment of addiction is seen as analogous to digging up a sick and dying tree, transplanting it into an environment of rich soil, sunshine, water, and fertilizer only to return it to its original deprived location once its health has been restored. What is called for is treating the soil—creating a Healing Forest within which the health of the individual, family, neighborhood, community, and beyond are simultaneously elevated. The Healing Forest is a community in recovery.

Achieving this integrated vision of personal, family, and community recovery will require addiction treatment programs and recovery community service organizations to move beyond intrapersonal models of addiction recovery and conceptualize broader and more sustained interventions. More specifically, this will require strategies of outreach (extending the reach of treatment organizations into the community), inreach (involving indigenous community recovery support resources within the treatment environment), and community-based recovery resource development (facilitating broader processes of community healing) (White, 2009).

As behavioral health care systems shift from a focus on pathology to a focus on recovery and resilience, their vision and service technologies will inevitably be forced to see the individual nested within the ecology of family and community. As that happens, the interconnectedness of personal, family, and community health will become increasingly apparent, and talk of individual and family recovery will be extended to that of community recovery. In places like Alkali Lake, British Columbia, and Philadelphia, Pennsylvania, that process is well under way.

About the Authors: William White is a Senior Research Consultant at Chestnut Health Systems. Dr. Arthur Evans, Jr. is Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS). Roland Lamb is the Director of the Office of Addiction Services, Philadelphia DBH/MRS.

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