

Published in abridged form in: Evans, A.C., Lamb, R. & White, W.L. (2013). The community as patient: Recovery-focused community mobilization in Philadelphia, 2005-2012. *Alcoholism Treatment Quarterly*, 31(4), 450-465.

**The Community as Patient:
Recovery-focused Community Mobilization in
Philadelphia, PA (USA), 2005-2012**

Arthur C. Evans, Jr, PhD, and Roland Lamb, MA
*Philadelphia Department of Behavioral Health and Intellectual disAbilities,
Philadelphia, Pennsylvania USA*

William White, MA¹
Chestnut Health Systems, Bloomington, Illinois USA

The concept of recovery within the addictions arena has historically referred to the resolution of severe alcohol and other drug (AOD) problems at a personal or family level. Larger social systems can also be wounded by and experience recovery from the prolonged effects of AODs and related problems. This paper explores the concept of community recovery, posits a set of preliminary principles related to community recovery, presents a case study of community recovery, and outlines current strategies used in the City of Philadelphia to promote processes of community recovery.

KEYWORDS *Recovery management, recovery-oriented systems of care, community recovery capital, community recovery, recovery support services*

Introduction

Recovery is emerging as a central organizing concept for the transformation of addiction treatment and the broader redesign of behavioral health care in the United States (Evans, 2008; ONDCP, 2010; ONDCP & SAMHSA, 2010; White, 2005, 2008a,b). Recent efforts to more precisely define recovery have emphasized reconstruction of the person-community relationship as a central element of the personal recovery experience. The Betty Ford Institute Consensus Panel (2007) included “citizenship” as a component of recovery, and the UK Drug Policy Commission Recovery Consensus Group (2008) included “participation in the rights, roles and responsibilities of society” in its definition of recovery. White (2007a), reflecting the broader conceptualization of recovery within Native American (Coyhis & White, 2006) and African American (Achara-Abrahams et

¹ Address correspondence to William L. White, MA, Chestnut Health Systems, 3329 Sunset Key Circle, Unit #203, Punta Gorda, FL 33955, email: bwhite@chestnut.org

al., 2012; Sanders & Powell, 2012; White & Sanders, 2008) communities, subsequently depicted recovery as a healing process that could move beyond individuals and families to encompass whole communities. Those spheres of recovery are graphically depicted below and placed within the framework of the Native American medicine wheel.

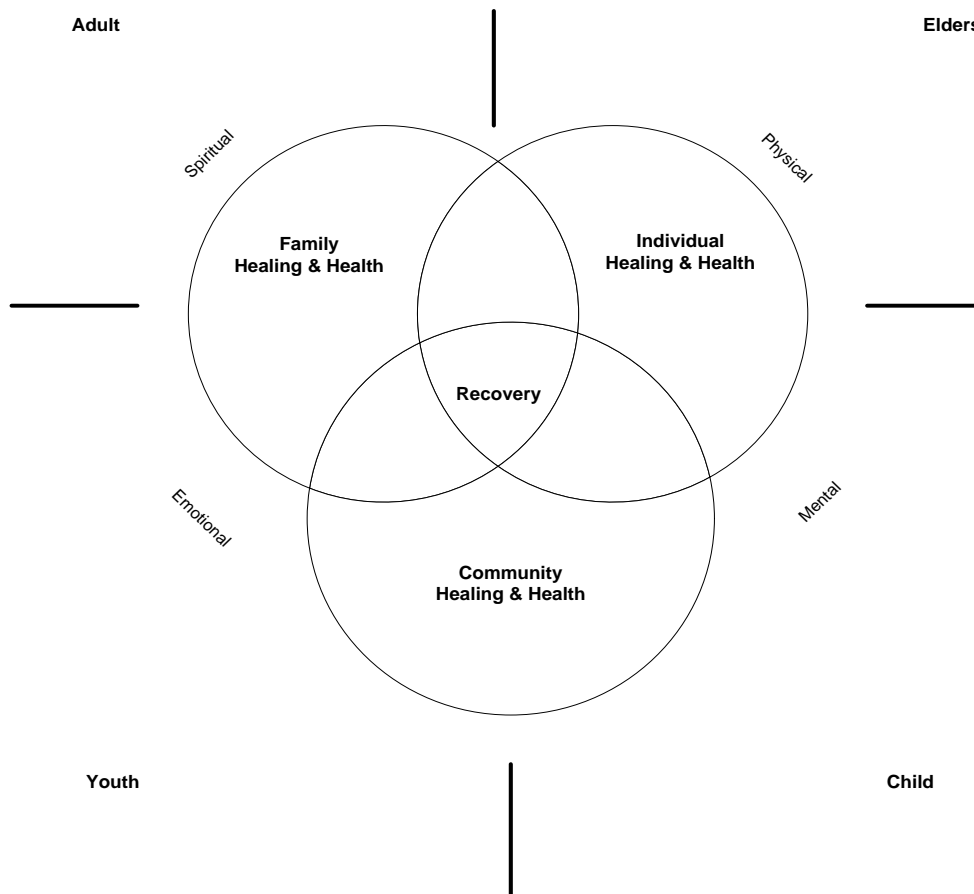


Figure 1 Recovery and the life cycle of the individual, the family and the community.

Source: Charlene Belleau, Former Chief, Alkali Band of Indians (White 2007a, p. 237)

While a process of community recovery has been suggested in this earlier work, the concept of community recovery has not been defined and amplified. The purpose of this article is to draw on the authors' collective experience within a recovery-focused behavioral health care 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.

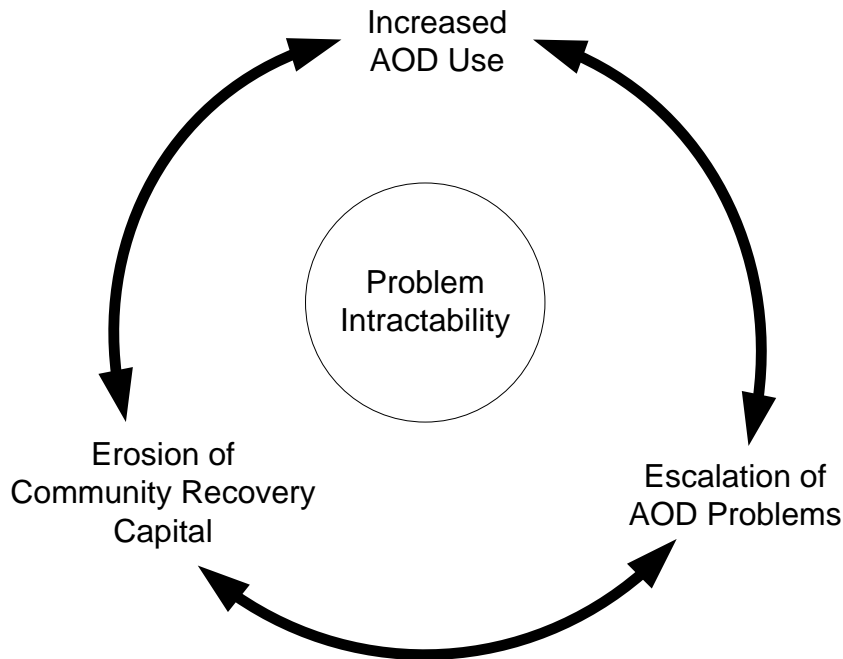


Figure 2: Problem Intractability and Personal/Community Demoralization

The etiology of AOD problems has long been portrayed within two primary organizing lenses: personal vulnerability (a genetically influenced disease process warranting medical treatment) and personal culpability (a moral weakness warranting character reconstruction or 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 (Humphreys, Moos, & Cohen, 1997; Karriker-Jaffe et al., 2012). These contextual influences constitute the soil in which AOD problems flourish or are squelched at personal, family, neighborhood, and community levels. These influences also determine whether severe AOD problems are personally and socially intractable or amenable to prevention, early intervention, treatment, recovery support, and broader community 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 demands for adaptation. Most communities have the

internal resources to respond to these stressors, and AOD problems in such communities remain primarily limited to a small percentage of community members with particular vulnerability for such problems and who are disconnected from community support systems. In such circumstances, problem contagion is limited and contained within marginalized subcultures.

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. Under conditions of community distress, personal, family, and cultural deterioration unfolds, and these elements interact synergistically to rapidly increase the prevalence and severity of AOD problems. Under these circumstances, problem contagion and its resulting progeny (e.g., family dissolution, child abuse/neglect, homelessness, crime, violence, infectious diseases) become shrouded in an aura of intractability that in turn feeds collective frustration, hopelessness, apathy, and resignation. This loss of community self-efficacy can trigger aggression—shunning, scapegoating, punishment, community extrusion—of those viewed as problem vectors.

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 socially contagious and 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; Brave Heart, Chase, Elkins, & Altschul, 2011; Morgan, 1983). Over time, learned helplessness and hopelessness in the face of such problems can become part of the community culture conveyed across generations awaiting a process of community recovery.

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 subsequent 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 a 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, Swidler, & Tipton, 1985).

- Weakened family, kinship network, neighborhood, and natural community ties diminish personal and collective capacities to respond to rising problems (Bloom, 1997).
- Alternative social structures (from gangs to mutual aid groups to cell phone and internet-based social networking) meet social support needs once met by traditional social institutions (e.g., families, extended families, churches, schools, workplaces, civic organizations; White, 2001).
- The industrialization and commercialization of personal compassion (via ever-growing health and social services agencies) and social control (via ever-growing police, courts, correctional, and child protection agencies) may have inadvertently hastened the dissolution of family, kinship, neighborhood, and community ties (McKnight, 1995).
- Interventions into AOD and related problems must move beyond micro-level (individual) interventions to the creation of “naturally occurring, healing environments” that simultaneously elevate personal, family, and community health (Bloom, 1997, p. 117).

Strategies of community development and renewal, embraced here within the conceptual rubric of *community recovery*, can complement 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, 2001, 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 levels of prevalence and severity that threaten collective health and functioning. In short, systems can become impaired by addiction and the broader arena of AOD problems and reach a level of such impairment that system vitality and viability are threatened. 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 are routinely collected by 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 breakthrough in community consciousness (acknowledgement and clear definition of problems) and sustained community commitment and 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; 4) enhancing the long-term health and quality of life within major community institutions and the community as a whole; and 5) implementing strategies designed to break intergenerational cycles of problem transmission.

Community recovery is a *process* in that it must unfold and be sustained over a prolonged period of time. It is not an event or a time-limited special project. 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 AOD-related problems and imbedding personal, family, and cultural resistance and resilience as an enduring intergenerational legacy within the fabric of community life.

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 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 and control 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, families, and neighborhoods; 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 past and continued 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 we were wounded by these problems?
- What happened to us as a result of these problems?
- What sparked the recovery process?
- Who and what are we now and where are we going as a community?

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; the arts community; and media institutions. The catalysts for community recovery can come from any one of these sectors, but the long-term recovery and community renewal is only possible 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 community recovery capital, e.g., increases in recovery prevalence, pro-recovery community policies, and enrichment of 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.). These resources can then be mobilized to reduce future levels of AOD problems within the community, creating strategic integration of harm reduction, primary prevention, early intervention, treatment, and recovery support efforts.

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

Community recovery elevates the prognosis for personal/family recovery by elevating external recovery capital, creating the physical, psychological, and cultural space where recovery can flourish, and increasing the density of recovery carriers (persons who convey infectious hope and guidance for recovery initiation/maintenance) within the community.

A Brief Case Study in Community Recovery

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 five 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, 2011; Wadden, 2008).

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).

Community Mobilization in Philadelphia

For the past five years, the authors have been involved with the Philadelphia Department of Behavioral Health and Intellectual disAbility Services’ recovery-focused system transformation efforts (See Achara-Abrahams, Evans, & Kenerson King, 2011; Evans & Beigel, 2006; Lamb, Evans, & White, 2009; White, 2007b). As this initiative 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 the idea of community recovery as both a goal and method.

Through this systems transformation process, several strategies emerged that promoted recovery at these multiple levels. 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 people from throughout the community	Conducting ongoing focus groups, town meetings, and other listening forums; eliciting personal, family, neighborhood, and community recovery 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. Personal and collective healing can occur through 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 between service providers and the larger community.	Distress breeds isolation and “us versus them” thinking at all levels of the community; closed systems open only via increased boundary transactions and cross-boundary relationships.
Forge or strengthen old and new partnerships	Desiloization: experiments in co-location; pushing integrated solutions to entangled problems; creating win-win outcomes for joint collaborations; 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 disease.
Create synergistic effects through integrated and linked projects	Funding recovery support services within non-traditional settings; experimenting with co-location of services and development of multi-agency service and support 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 local communities.
Strengthen natural supports beyond professional service systems	Supporting grassroots efforts that provide support to the broader community; developing faith-based initiatives related to substance use prevention and personal/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.	Long-term recovery support is best provided within relationships that are natural, non-hierarchical, non-professionalized, non-commercialized, and marked by sustained continuity of contact over time. The first-line of recovery support is the community; professional treatment is the safety net.
Promote tolerance, respect, and	Increasing contact between people affected by different challenges and between such individuals and	Intolerance, stigma, and intergroup conflict are symptoms of community distress. The most

mutual support	members of the larger community; creating a stigma committee to develop a strategy for long-term stigma reduction.	effective stigma reduction strategy is a relational contact strategy.
Inspire hope	Hosting recovery celebration events and recovery conferences; sponsoring recovery mural arts projects in the community; Recovery Idol music contests; importing and locally developing charismatic speakers on addiction recovery and recovery advocacy.	Recovery initiation hinges on changing prevailing pessimism—elevating the idea that personal, family, and community recovery is both possible and a growing reality. People who were once part of the problem can be transformed and mobilized as part of the solution.
Cultivate a network of recovering communities for mutual support	Visibly promote community recovery successes; exchange visits with other communities at national and international levels for mutual support and sharing of ideas and methods.	Internal and external recognition of local community efforts increases community self-esteem and enhances motivation for sustained system transformation efforts.
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 Recovery Advisory Committees and multiple time-limited task forces.	Community recovery initiation is enhanced by mobilizing internal recovery capital. Community service is a vehicle of personal and community healing. Expanding service opportunities for people in recovery enhances personal and community recovery.
Mobilize external resources	Increasing procurement of federal, state, 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.
Increase trust	Maintaining consistent 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	Providing centralized training of all stakeholders and recovery community	Diversity of communication strategies must reflect knowledge

the vision, core ideas, and values	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.	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 community.
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 frontline 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.
Measure community recovery capital	Mapping problem severity and recovery capital by zip code; conducting recovery prevalence surveys; establishing recovery-focused system performance benchmarks.	Resources can be strategically allocated to ensure that efforts to increase recovery capital reach those areas in greatest need. Solutions-focused public communications enhance community optimism and expand recovery support capacity.
Steward limited financial resources	Providing free consultations on recovery support development; using mini-grants to treatment providers, recovery community organizations, and other service organizations to expand availability and quality of recovery support services.	Many efforts that increase community recovery capital require minimal or no financial resources.

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 people in need and indigenous recovery support resources. Those resources included professional assistance

in recovery initiation, but the emphasis was on support that was voluntary, reciprocal, enduring, and non-commercialized (Mulford, 1976, 1978; White, 2001, 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, treat, and discharge individuals and families impacted by severe alcohol and other drug problems. That approach, upon which the modern addiction treatment industry was built, defined the source and solutions to addiction at the microsystem level (individual and limited attention to family). Neither model conceptualized the community as the “patient” (White, 2003).

In contrast, a profound understanding of the concept of wounded community and the potential for community recovery can be found within historically disempowered groups, particularly within 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, 2002). 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 and subsequently lost again. What is called for in this metaphor 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 ecologically nested within 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 already well under way.

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

Acknowledgement: Support for the development of this paper was provided by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

References

- Abbott, P. J. (1998). Traditional and western healing practices for alcoholism in American Indians and Alaskan Natives. *Substance Use and Misuse, 33*(13), 2605-2646. doi:10.3109/10826089809059342
- Achara-Abrahams, I, Evans, A. C., & Kenerson King, J. (2011). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science.
- Achara-Abrahams, I., Evans, A. C., Ortiz, J., Villegas, D. L., O'Dell, J., Ali, O., & Hawkins, D. (2012). Recovery management and African Americans: A report from the field. *Alcoholism Treatment Quarterly, 30*, 263-292. doi:10.1080/07347324.2012.691049
- Bellah, R., Madsen, R., Sullivan, W., Swidler, A., & Tipton, S. (1985). *Habits of the heart: Individualism and commitment in American life*. New York: Harper & Row.
- Ben, L. W. (1991). *Wellness circles: The Alkali Lake model in community recovery processes* (Unpublished doctoral dissertation). Northern Arizona University, Flagstaff.
- Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*(3), 221-228. doi:10.1016/j.jsat.2007.06.001
- Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge.
- Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13. doi:10.1080/02791072.2003.10399988
- Brave Heart, M. Y., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research and clinical considerations. *Journal of Psychoactive Drugs, 43*(4), 282-290. doi:10.1080/02791072.2011.628913
- Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal, 8*(2), 60-82.
- Chelsea, P., & Chelsea, A. (Producers). (1985). *Honour of all: The people of Alkali Lake* [Video]. British Columbia, Canada: The Alkali Lake Tribal Council.
- Coyhis, D., & White, W. L. (2002). Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly, 20*(3/4), 157-165. doi:10.1300/J020v20n03_10
- Coyhis, D. L., & White, W. L. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery*. Colorado Springs, CO: White Bison, Inc.
- Douglass, F. (1855). *My bondage and my freedom*. New York: Miller, Orton, & Mulligan.
- Evans, A. (2008). *The recovery-focused transformation of an urban behavioral health care system*. In W. L. White (Ed.), *Perspectives on systems transformation: How*

- visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonna Albricht)* (pp. 39-58). Chicago, IL: Great Lakes Addiction Technology Transfer Center.
- Evans, A. C., & Beigel, A. (2006, February). *Ten critical domains for system transformation: A conceptual framework for implementation, evaluation & adaptation*. Presented at the 16th Annual Conference on State Mental Health Agency Services Research, Program Evaluation & Policy, February, Baltimore, MD.
- Hacker, G., Collins, R., & Jacobson, M. (1987). *Marketing booze to Blacks*. Washington, DC: Center for Science in the Public Interest.
- Haggerson, P. (2011). The honour of all: Twenty-five years of inspiring recovery from alcoholism. *Counselor*, 12(5), 10-13.
- Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58(3), 231-238.
- Karriker-Jaffe, K. J., Zemore, S. E., Mulia, N., Jones-Webb, R., Bond, J., & Greenfield, T. K. (2012). Neighborhood disadvantage and adult alcohol outcomes: differential risk by race and gender. *Journal of Studies on Alcohol and Drugs*, 73, 865-873.
- Lamb, R., Evans, A. C., & White, W. L. (2009). *The role of partnership in recovery-oriented systems of care: The Philadelphia experience*. Retrieved from www.facesandvoicesofrecovery.org
- Lurie, N. (1974). The world's oldest on-going protest demonstration: North American Indian drinking patterns. In N. Hundley (Ed.), *The American Indian* (pp. 55-76). Santa Barbara, CA: CLIO Books.
- McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books.
- Morgan, P. (1983). Alcohol, disinhibition, and domination: A conceptual analysis. In R. Room & G. Collins (Eds.), *Alcohol and disinhibition: Nature and meaning of the link* (pp. 405-422). Washington D.C.: U.S. Government Printing Office.
- Mulford, H. (1976, June). *Alcohol abuse and citizen action: The community counselor/consultant approach*. Presented at the Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependence, Toronto, Canada, June 20-25, 1976.
- Mulford, H. (1978, September). *Accelerating the natural alcoholic recovery process*. Presented at the 32nd International Congress on Alcoholism and Drug Dependence, Warsaw, Poland.
- ONDCP. (2010). New drug policy approach focuses on vital role of recovery. *ONDCP Update*, 1(1), 2. Washington D.C.: Office of National Drug Control Policy.
- ONDCP & SAMHSA. (2010). *National summit on recovery from substance use disorders, September 14, 2010*. Washington D.C.: Office of National Drug Control Policy and Substance Abuse and Mental Health Services Administration.
- Sanders, M., & Powell, J. (2012). Multiple pathways of recovery for African American men. *Alcoholism Treatment Quarterly*, 30(3), 315-325.
doi:10.1080/07347324.2012.690697

- The red road to wellbriety* (2002). Colorado Springs, CO: White Bison, Inc.
- Taylor, V. (1987). The triumph of the Alkali Lake Indian band. *Alcohol Health and Research World*, 12(1), 57.
- The UK Drug Policy Commission Recovery Consensus Group. (2008). *A vision of recovery*. UK Drug Policy Commission.
- Wadden, M. (2008). *Where the pavement ends: Canada's aboriginal movement and the urgent need for reconciliation*. Vancouver, British Columbia: Douglas & McIntyre.
- Waldorf, D. (1973). *Careers in dope*. New Jersey: Prentice Hall.
- White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.
- White, W. L. (2001). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly*, 19(4), 1-32. doi:10.1300/J020v19n04_01
- White, W. L. (2003). The road not taken: The lost roots of addiction counseling. *Counselor*, 4(2), 22-23.
- White, W. L. (2005) Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 23(1), 3-15. doi:10.1300/J020v23n01_02
- White, W. L. (2007a). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33(3), 229-241. doi:10.1016/j.jsat.2007.04.015
- White, W. L. (2007b). A recovery revolution in Philadelphia. *Counselor*, 8(5), 34-38.
- White, W. L. (2008a). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse*, 43(12&13), 1987-2000. doi:10.1080/10826080802297518
- White, W. L. (2008b). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright)*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.
- White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-158. doi:10.1016/j.jsat.2008.10.006
- White, W. L. (2010). *Recovery is contagious*. Retrieved from www.facesandvoicesofrecovery.org and www.williamwhitepapers.com.
- White, W. L., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, 26(3), 365-395. doi:10.1080/07347320802072198
- Williams, C., with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York: Harper San Francisco.