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EXTENDING THE BENEFITS OF ALCOHOL AND DRUG TREATMENT:
AN EXPLORATION OF VOLUNTEER UTILIZATION
AND DELIVERY OF RECOVERY SERVICES

A Research Project
Presented to the Faculty of
The George L. Graziadio
School of Business and Management
Pepperdine University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Organization Development

by
Leonard L. Bade II

August 2010

This research project, completed by

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under the guidance of the Faculty Committee and approved by its members, has
been submitted to and accepted by the faculty of The George L. Graziadio
School of Business and Management in partial fulfillment of the requirements for
the degree of

MASTER OF SCIENCE
IN ORGANIZATION DEVELOPMENT

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Abstract

This thesis explored what treatment providers can learn from community-based organizations about volunteerism as a way to support long-term alcohol and drug recovery. In particular, this thesis used 11 structured interviews with staff at community-based organizations and treatment centers to determine the level of resource allocation of volunteers, the utilization of volunteers in program and service delivery, and the motivation of volunteers to get and stay involved in recovery activities. Gaining a better understanding of volunteerism as a strategy for extending care beyond a treatment setting had benefits for both treatment center alumni and volunteers. Findings supported previous anecdotal and research evidence that there were enormous benefits for alumni and the volunteers as recovery was most often enhanced for the volunteer when the experience of recovery was shared with others who were new to a recovery lifestyle. The present research also supported the belief that alumni of treatment centers were less likely to relapse when longer post-treatment recovery support was provided. The findings suggested ways to extend treatment of alcohol and drug addiction beyond the formal treatment setting into the home environment and improve recovery outcomes.

Table of Contents

	Page
Abstract	iii
List of Tables	vi
Chapter	
1. Introduction	1
Statement of the Problem	5
Purpose.....	6
Organization of the Study.....	7
2. Literature Review	8
Post-Treatment Recovery Support.....	8
Value of Using Peer Support in Post Alcohol and Drug Treatment: Lessons Learned from Alcoholics Anonymous.....	12
The Use of Volunteers and Peer Support by CBOs	15
Summary.....	19
3. Methods	22
Interview Protocol.....	23
Sample	24
CBOs.....	24
Treatment Programs	26
Data Collection.....	28
Limitations	30
4. Research Findings	32
Differences Between Treatment Centers and CBOs.....	32
Goal Similarities: Differences in Delivery	34

Chapter	Page
Motivations for Volunteerism	37
Commitment of Resources to Volunteers.....	39
CBO Volunteer Training	40
Treatment Center Volunteers.....	45
Utilization of Volunteers: Scope	47
Alumni Services for Treatment Centers	55
Other Relevant Recovery Services	60
Summary.....	61
5. Summary and Conclusions	63
Impact of Study	66
Limitations of Study.....	67
Recommendations and Considerations	68
Summary.....	72
References	74
Appendix: Interview Protocol	78

List of Tables

Table	Page
1. Research Census Grid.....	28
2. Differences Between Treatment Centers and Community-Based Organizations.....	33
3. Community-Based Organization Family Support	35
4. Community-Based Organization Volunteer Recognition	37
5. Recovery Coaching and Leadership Training in Community-Based Organizations.....	41
6. Certification and Specialist Training at Community-Based Organizations.....	42
7. Volunteer Training Fundamentals in Community-Based Organization	44
8. Treatment Center Alumni Peer Support in Treatment.....	46
9. Treatment Center Volunteer Structure	47
10. Specialized Recovery Workshops and Programs Offered at Community-Based Organizations	50
11. Women's Recovery Support Offered at Community-Based Organizations.....	51
12. Advocacy and Community Outreach in Community-Based Organizations.....	53
13. Unique Programs Offered by Community-Based Organizations.....	55
14. Treatment Center Alumni Roles.....	56
15. Treatment Center Alumni Contacts.....	58
16. Treatment Center Alumni Chapter Groups	58
17. Treatment Center Alumni Services Follow up with Alumni.....	59

Chapter 1

Introduction

Over 22 million Americans suffer from addiction or alcohol and drug dependency. The report *Results from the 2006 National Survey on Drug Use and Health: National Findings* estimated that in 2006, 23.6 million persons aged 12 or older needed treatment for illicit drug or alcohol abuse, but only about 2.5 million were actually admitted to facilities for treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). Thus, 21.1 million did not receive treatment. The cost of untreated addiction to society is difficult to gauge. However, some estimates have suggested the economic sacrifice associated with untreated addiction costs Americans more than 100,000 lives and nearly half a trillion dollars annually (Harwood, 2000).

While some of these individuals seek and access treatment, others have no real familiarity with or understanding of long-term recovery from addiction (SAMHSA, 2007). Treatment alone, without effective recovery resources extending into post-treatment, has limited effectiveness. Of clients who complete specialized addiction treatment, more than 50% resumed alcohol or other drug use within the year (Anglin, Hser, & Grella, 1997). Unfortunately, most resumed usage within 90 days after their treatment discharge date (Hubbard, Flynn, Craddock, & Fletcher, 2001). Given the scope of the addiction problem and the limits of current recovery models, there are critical public health and economic incentives for identifying cost-effective ways to extend treatment benefits to those who want and need help after leaving a formal treatment setting.

Drug and alcohol treatment methods and services have changed dramatically over the past two decades. Formerly, clients in addiction treatment received the full spectrum of services from one single provider. At the time of this study, it was common for patients to receive a broad range of care from multiple institutions. For instance, clients could detoxify in one place, enroll for inpatient treatment elsewhere, enlist intensive outpatient services in a third location, and use aftercare programs at a fourth facility. At each distinct stage of treatment, the individual institutions maintained responsibility for their service specialty; yet, no one organization took responsibility for maintaining continuous monitoring and long-term contact with the client. Commonly, specific organizations neither followed the clients' progress through the distinct stages of treatment, nor did they subsequently support them as they moved into recovery. Research on relapse has suggested this treatment gap results in a heavy cost to individuals, families, and society.

Acute-care treatment provides detoxification, stabilization, and initiates a period of abstinence, while providing psychological, physiological, and social support. However, the acute-care model often mistakes periods of sobriety with sustained long-term recovery, thus, failing to provide recovering addicts with much-needed assertive recovery support beyond the treatment episodes (White, 2008). The structure of acute care inadvertently supported this phenomenon and research revealed "that a growing number of system-sophisticated clients have acquired skills in recovery initiation, but repeatedly relapse due to their failure to make the transition to recovery maintenance in natural, non-institutional environments" (White, 2009a, p. 151). White also stated that instead of repeated

treatment episodes, a more successful approach was to develop a process of focused interventions at the individual, family, and community levels. Vital to this strategy was the challenge of transferring knowledge “from the institutional environment to the natural environment of its clients” (p. 151). In short, the client, family, and community needed maintenance skills that could build a sufficient reserve of recovery capital critical for successful long-term recovery.

Alcohol and drug relapses are prevalent and come in many forms. All have different names and are characterized by unique lengths and styles. These periods of returning to drinking or drug use have been termed slips, lapses, binges, or relapse. Each term defined varied levels of time and intensity of the return to drinking or drug use. Regression to compulsive usage was a magnification of pre-treatment usage that could be quite extensive before sobriety was sought or achieved (Hubbard et al., 2001). Relapse episodes are actually a condition of the disease of alcoholism, and rarely does a single treatment experience eliminate relapse entirely. However, research and experience showed that rates of relapse could be minimized when treatment support programs continued to improve and were lengthened (McKay, 2009).

Treatment centers occasionally had strategic plans designed to nurture, support, and develop local and community recovery groups for clients returning to their home environment. Typically, these plans included developing skills and creating strategies for maintaining strong recovery. The primary purpose of such groups was to facilitate the sufficient lifestyle reconstruction essential to successful long-term recovery for the client, thereby potentially reducing relapse rates. Local and regional recovery support groups could widen entry to the

doorway of recovery. While some strategies for post-treatment recovery support existed, there was little research about their specific elements and the role of peer and alumni support, especially the role of volunteerism. This oversight suggested that the treatment community could benefit from a better understanding of ways to extend the benefits of alcohol and drug treatment beyond the formal setting.

Peer support and alumni involvement were potentially the critical links to help the newly discharged patient sustain an often-tenuous recovery beyond the formal treatment environment. This thesis sought to identify best practices in community-based organizations (CBOs) that rely on volunteerism in the field of alcohol and drug recovery, with emphasis on those practices that could be mobilized to extend the benefits of treatment. In particular, the present study explored what treatment providers could learn from CBOs about volunteerism as a way to support long-term recovery in a cost-effective way. Utilizing volunteers and peer support for delivery of post treatment recovery services provided additional benefits for alumni and volunteers since research demonstrated that helping others was a key for maintaining sobriety (Zemore & Pagano, 2009).

There are two types of treatment organizations where peers or alumni of the program can and do play a role in recovery support. The first type is a standard inpatient treatment center, where an individual receives either primary care (typically 30 days in length) or extended care (varying between 60 days and 1 year) in a residential setting, often at great distance from the individual's home. Although these centers offer outpatient services, their primary focus is inpatient treatment. The second type is a CBO, where the individual receives intensive

professional and peer support in his or her local community. Treatment might or might not be offered in addition, A major goal of CBOs is to connect individuals to resources within the community (including peer support) that provide recovery services.

The gap between treatment and recovery emerges in different ways between inpatient treatment and CBOs. Unlike treatment centers, CBOs often lack the funding to bolster and support professional recovery services, ongoing communications, and technical systems. Alternatively, treatment centers often lack the follow through in the recovering alumni's home community. This thesis hypothesized that as a way to support continuing recovery, treatment providers could learn from CBOs and volunteerism to influence patient outcomes in a positive and cost-effective way.

Statement of the Problem

The most common treatment programs are short term and commence with the brief, yet critical 3- to 7-day medical detoxification. Until recently, the industry standard was a 28- to 30-day inpatient treatment program. At present and quite frequently, treatment programs extend to 90 days or longer. Research and experience has indicated that successful long-term recovery improved as the time interval of treatment increased. According to Simpson, Joe, Fletcher, Hubbard, and Anglin (1999), the extended length of time in treatment was a predictor for positive treatment outcome for cocaine addicts.

Only a few treatment programs offer a bridge to dynamic ongoing recovery support for patients upon discharge. Most programs lack sufficient funds, particularly in the nonprofit sector, to provide vital continuing care for their clients.

Thus, using volunteers as a low-cost strategy to deliver support services in a systemic and thoughtful manner could do much to overcome the risk for relapse. Alumni who share a common treatment experience and familiarity with the institution are logical choices for providing support. Additionally, alumni who successfully practice tools and skills received in treatment are valuable and cost-effective resources for treatment programs. In spite of the potential for building a bridge that supports recovery, this model has not yet been maximized by strategies utilizing volunteers. Rather, most research on post-treatment outcomes focuses on the effects of 12-step programs in recovery, peer support in CBOs, and treatment outcomes. Less is known about combinations of post-treatment services and community-based services that could potentially work together for enhanced recovery support in the aftercare environment.

Purpose

This thesis explored the use and value of peer support programs as a critical resource for sustaining recovery when clients depart treatment programs and return to their home environment. It identified those best practices that narrowed the chasm between treatment and post-treatment using open-ended interviews with CBOs and treatment providers. The practical significance of this thesis was to make recommendations of practices that could be duplicated, made relevant to local organizations, and incorporated into treatment programs or CBOs.

This research examined how two different organizational structures, CBOs and treatment programs, created value by integrating recovery support programs with peer-based service. Exemplar organizations and programs were selected for

interview. These programs provided a nearly seamless link between the treatment environment and the client's home environment. By compiling and comparing these two very different approaches, best practices emerged. These best practices can be used to inform treatment providers at alcohol and drug treatment facilities about using volunteerism as a way to support long-term recovery in a cost effective way.

Organization of the Study

Chapter 2 describes the literature in three critical areas of treatment and recovery from alcohol and drug addiction: research correlating the length and quality of post-treatment support with relapse prevention and recovery success, studies that evaluated the use of peer support in post-treatment recovery for alcohol and drug treatment, and a review of characteristics of volunteers and peer support used by CBOs. Chapter 3 describes the methods used in the present study, in which face-to-face interviews were conducted with representatives from seven organizations: four CBOs and three treatment centers.

Chapter 4 reports the findings from the research. In particular, these services and practices were then compared with the goal of determining which strategies from the CBOs might be valuable for augmenting existing post-treatment recovery curricula. Chapter 5 discusses the impact of the study, limitations of the study, and recommendations and considerations.

Chapter 2

Literature Review

The current study explored using a peer support system to extend the benefits of inpatient treatment for alcohol and drug abuse beyond the clinical environment. The following literature review examined research in three critical areas: (a) ways that extending treatment and post-treatment recovery support services enhance continuous recovery, (b) the value of using peer support in post alcohol and drug treatment, and (c) use of volunteers by CBOs. This chapter emphasizes service integration immediately following alcohol and drug treatment and the role that peer support practices may play in post-treatment recovery.

Post-Treatment Recovery Support

The long standing model of acute care for alcohol and other drug addiction was typically characterized by the following elements, often in this sequence: screening; admissions; assessment; a series of educational, individual, and group therapeutic processes; discharge; and recommendations after discharge by professional staff for continuing care and follow up. Then, a treatment curriculum was carried out by professionals, which primarily addressed the problem of alcohol and drug addiction with some subsequent dually diagnosed mental illnesses. Addiction has long been characterized as a chronic illness; yet, in the span of an individual's lifetime, each treatment experience tends to be a brief and critical intervention. Ongoing long-term monitoring, attention, and support are essential for the management of chronic illness. After the completion of addiction treatment, individuals precariously balance between recovery and re-addiction. Thus, peer-based recovery support becomes the missing link to stable

recovery. White (2009b), a leading treatment professional and recovery author, observed that, "Recovery is not fully stable and durable (the point at which the risk of future lifetime relapses drops below 15%) until after 4-5 years of continuous sobriety" (p. 79).

Continuing care and aftercare are stages of recovery support after the initial treatment episode. In McKay's (2009) review of 20 controlled studies from the 1980s to 2005, continuing care interventions proved more likely to produce positive treatment effects when they were of a longer duration and when providers made more assertive efforts to deliver treatment to patients. McKay's review yielded two significant conclusions about continuing care effectiveness. First, he found that, "Interventions with a longer planned duration of therapeutic contact appear to hold an advantage over shorter interventions, although more carefully controlled research is necessary in this area" (p. 142). Second, his review showed:

Interventions that feature more active and direct attempts to bring the treatment to the patient, either through aggressive outreach attempts or the use of low burden service delivery systems, such as the telephone, are effective or seem to have a clear advantage over more traditional approaches. (McKay, 2009, p. 142)

Regardless of the quality or quantity of effective interventions, patients often did not choose to participate. In fact, the majority of patients chose to forego continuing care activities altogether (McKay et al., 2004). Consequently, new continuing care models that complement traditional clinical-based programs may warrant further consideration. Key elements for future models could include aggressive attempts to stay in touch with patients over extended periods of time, structured treatment recovery plans modified to the individual's specific recovery

needs, services that are less burdensome and more convenient for the patients, and choices for patients about types of treatment and their settings. While the acute-care model of treatment for alcohol and drug addiction remained a critical component to initiate recovery, a more comprehensive link to recovery support strategies in one's home environment was vital to ensure longer-term recovery success (Humphreys, Moos, & Finney, 1995). There was a gap between the professional alcohol and drug treatment entities and more sustained community-based recovery support models. There was also growing evidence that the recovery initiation process of alcohol and other drug treatment did not guarantee sustained recovery once the patient returned to their originating environment (Weisner, Matzger, & Kaskutas, 2003; Westmeyer, 1989). For example, White (2009a) stated,

Professional resources should never be used to meet a need that can be met within community relationships that are natural, enduring, reciprocal, and not commercialized. The goal of professional intervention, based on the ethical values of autonomy and stewardship, is ideally the mobilization of both personal/family resources and community resources to minimize the need for professional assistance. Treatment is best thought of as an adjunct of the community rather than the community being viewed as an adjunct of treatment. (p. 152)

White (2009a) also stated, "The greater the physical, psychological, and cultural distance between a treatment institution and the natural environments of its clients, the greater is the problem of transfer of learning from the institutional to the natural environment" (p. 151). He added, "The chasm between institutional and natural environments can be lessened by extending the service process into the daily life of the community and by inviting the community into the daily life of the service institution" (p. 151).

The risk of relapse often is directly linked to problems in the home environment. For example, Marlatt, Barrett, and Daley (1999) found three primary high-risk situations that were associated with 75% of all relapses reported. The first risk was a negative emotional state, predominantly characterized by frustration, boredom, depression, and anxiety. The second was external pressure to resume prior drinking behavior, and the third was interpersonal conflict in a relationship with family, friends, or coworkers.

In addition to the quality of the transition from treatment to the home environment, the duration of follow-up treatment also was linked to relapse prevention and patient outcomes. Simpson et al. (1999) revealed in one study about the length of treatment in relation to the severity of cocaine dependency that the longer the treatment stay, the more positive the effect on those with the severest dependency. Essentially, the more severe the drug dependency identified during admissions intake and the shorter the treatment stay, the higher the relapse rate.

Other studies explored this link between duration of follow up and positive treatment outcomes as well. In research on relapse rates for heroin and cocaine users, Hubbard et al. (2001) found that approximately 80% of their subjects relapsed within 3 months after treatment and hypothesized that an increased focus on continuing care services within the community might reduce relapse rates. Similarly, work by Fiorentine and Hillhouse (2000) indicated that the longer the treatment episode, the more likely the participation in 12-step programs after treatment. Furthermore, this study implied that incorporating 12-step principles in the treatment curriculum may increase the likelihood of sustained recovery.

*Value of Using Peer Support in Post Alcohol and Drug Treatment: Lessons
Learned from Alcoholics Anonymous*

Much of the research for post-recovery support has focused on the 12-step model. Twelve-step programs are mutual aid organizations that embrace those who seek help arresting their addiction. These programs are based upon the 12-step philosophy and design for recovery characterized by growing one's individual maturity, spirituality, selflessness, and desire to live a service-oriented life that is focused on helping fellow alcoholics or addicts (Humphreys & Wing, 2004).

The role of focused peer-based support through the workings of Alcoholics Anonymous (AA) and other 12-step mutual aid groups is well documented in the recovery literature. AA has been available globally to recovering persons through more than 114,561 meetings in over 150 countries with participation of more than 2 million recovering persons (Alcoholics Anonymous, 2005). Research conducted by Morgenstern, Labouvie, McCrady, Kahler, and Prey (1997) suggested that increased affiliation with AA after formal treatment was associated with better substance use outcomes. In particular, the research by Morgenstern et al. indicated that increased involvement with AA contributed to the development of healthy coping skills needed for sustained abstinence. Morgenstern et al. stated that, "AA's association with outcomes was mediated by its effects on sustaining beliefs in the cost-benefit of maintaining behavior change, commitment to a specific goal, and ability to achieve this goal and through promoting active coping efforts" (p. 774).

It was significant that attendance at AA meetings was also correlated with aftercare group attendance. Caldwell and Cutter (1998) studied 55 patients during the 3 months after discharge from structured treatment when dropout is highest. Three levels of meeting attendance were discerned: low, mid-level, and the well-known recovery standard of 90 meetings in 90 days. The assessment addressed low (<20), medium (20-59), and high (>70) levels of meeting attendance as well as using the spectrum of tools offered within the AA program, including service and sponsorship. The low-level and mid-level AA meeting attendees participated erratically in their assigned aftercare group while the high level AA meeting attendees attended their aftercare group more consistently.

In addition to aftercare attendance, this study also identified a wide range of recovery activities associated with AA participation. The activities reviewed include but were not limited to having a sponsor, talking with a sponsor, socializing before and after the meetings, contacting other AA members in between meetings, having a home group as a primary affiliation, assisting in commitments at meetings, working the 12 steps, sharing AA recovery stories, reading AA literature, and believing in a Higher Power. Caldwell and Cutter (1998) measured an individual's degree of involvement of the three levels of attendees relative to each activity and concluded that many subjects may experience barriers to intimacy upon entering a new group, which calls for the emphasis on improved communication and social skills, in addition to further exploration of one's spiritual practices. Importantly, they also found that professionals and peers needed a better grasp on the specific recovery principals in AA beyond simply encouraging meeting attendance and affiliation.

Emrick's (1999) work also explored the benefits of AA, specifically its structured community for individuals seeking a common solution for the disease of alcoholism and addiction. The benefits of mutual support provided by these groups were abundant. According to Emrick, these benefits included offering individuals a renewed meaning and purpose for life, opportunities for gaining personal insight into feelings and behaviors, improving relationships with others, and experiencing, expressing, and sharing emotions in surroundings rich with unconditional love and acceptance.

Research on stress reduction and quality of life among heroin addicts by Laudet, Morgen, and White (2006) concluded that one's positive outlook on life was the impetus for participation in recovery programs which have social, spiritual, religious, and 12-step components. In addition, the study found that the longer one participates in recovery, the more stress is reduced, and quality of life improves. Their research concluded that encouragement, acceptance, and a sense of belonging derived from 12-step participation were significant to establishing a beneficial, supportive social recovery network.

While studying an existing body of research of 12-step groups, Brown, Kinlock, and Nurco (2001) discovered it was difficult to integrate research with 12-step programs. Twelve-step groups, under their own initiative, found neither the need for evaluations, nor a need for public funding, and remarkably were fully self-supporting. Twelve-step groups did not have staff, medications, or any treatment curriculum. Despite all of the above, the groups continued to grow in size, appeal, and reputation through simple principles, informal communications, and word of mouth. Inpatient and outpatient treatment programs, which

integrated and 12-step principals into their curriculum, strongly confirmed the effectiveness of these programs.

The Use of Volunteers and Peer Support by CBOs

Until recently, the predominant focus of alcohol and drug research was on treatment and substance use outcomes. More recently, some studies have focused on individual elements of post-treatment support. This section of the literature review explored the current state of knowledge regarding peer support in recovery, including a new emphasis on volunteerism as a particular form of peer support in CBOs.

There were parallel behavioral characteristics between staff and peer volunteers that also were found between peer volunteers and the recovering persons they support. For example, Woody, Mercer, and Lubosky (1999) described therapist qualities that have positive effects on treatment retention and success. Qualities that have positive foretelling outcomes included interest in helping others, flexibility, and the quality of the helping relationship. In the early stages of the relationship with a therapist, positive behavioral interactions provided better treatment outcomes. Research further suggested that when the therapist had a high degree of empathy, confidence, and hope, combined with a low desire to control, the likelihood of a patient's positive treatment result increased. Conversely, when a therapist's voice inferred anger or anxiety, positive outcomes were reduced. While these studies were focused on therapists in a treatment setting, it is worth noting that these fundamental human traits became equally important to the newly recovering person. When peers exhibited

empathic, supportive, and compassionate confidence toward the new recovering person, it tended to endear the newcomer to the recovery process.

Pagano, Friend, Tonigan, and Scott (2004) studied the impact of helping others in AA. In conjunction with project MATCH, 1,726 people with alcohol abuse and dependence disorders participated in the study. Their research found that those who helped others, regardless of the extent of meeting attendance, were less likely to relapse in the first year of sobriety. The research further indicated that those AA members who helped others in recovery were more likely to maintain their own long-term sobriety than those who did not help others.

Cross, Morgan, Mooney, Martin, and Rafter (1990) reported similar findings:

Two hundred male and female patients, selected at random from all patients admitted to an inpatient alcoholism treatment facility in 1973-1974, were surveyed 10 years following treatment. Response rate was 80%, and a validity check was done. Of the 158 usable responses, 61% reported complete or stable remission of their alcoholism for at least 3 years prior to the survey and 84% reported stable psychosocial status. Successful outcome was possible, regardless of severity of drinking history or psychosocial status. Seventy-six percent (76%) of those still alive at follow-up reported remission; at most, 23% of the deceased were reported in remission prior to death. Involvement in Alcoholics Anonymous (AA) predicted abstinence, suggesting successful outcome for patients who undergo a treatment regimen, which bridges patients into AA involvement. Of those respondents who continued to sponsor other AA members throughout the follow-up period, 91% were in remission at the time of survey. (p. 169)

Beyond the AA model, De Leon (1999) also presented findings featuring peer support in post-treatment. His research focused on therapeutic communities and submitted that peers, serving as powerful role models, may be a highly effective mediating presence in the recovery process. Peers, as well as staff who displayed positive sober behaviors, actually lived sober values, and

demonstrated the teachings of the recovery community were incredibly powerful influences on a newly recovering person.

De Leon's (1999) research found that peers, serving as role models, were expected to show responsible concern for the members of their community. This entailed being willing to confront the behaviors of other members of the community when it was not in keeping with the norms of the therapeutic community or the expectation of recovery growth and rehabilitation. In addition to De Leon, Galanter (1999) wrote about the value of building a support network consisting of family, friends, coworkers, and significant others in one's natural environment to help strengthen recovery and foster positive attitudes. The goal of this network team was to encourage abstinence and adopt a drug-free life. This group was often supported and trained by professionals and functioned as a complement to individual and group therapy.

Given this understanding of the vital role that peer support and volunteers could play in post-treatment recovery from alcohol and drug abuse, it followed that there were a number of successful peer-based support models and mechanisms in place. White (2009b) has written extensively about peer support and post-treatment support in his recent publication, *Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. This work focused on peer-based recovery support shifting the care for people with alcohol and drug problems from pathology to a long-term recovery paradigm. Another key principle was to shorten addiction cycle and to lengthen the recovery life, consequently improving the quality of life for the individual, family, and life in long-term recovery.

White's (2009b) recent publication included program profiles of the CBOs chosen for this study and is briefly described below. White's publication profiled a number of programs, primarily in the City of Philadelphia, that have high relevance and success as peer support models, including

1. Peer group facilitation training, which enhances the peers in recovery to organize and facilitate support groups and other recovery, related meetings.

2. PROACT, which provides support to individuals and families in recovery through community education, policy advocacy, recovery support services, recovery celebration and recreation and community service.

3. A recovery walk, which is held annually to celebrate recovery, honor leaders in recovery, and exhibit treatment and recovery support organizations.

4. The new pathways project (assertive street and community outreach), designed "to reach the unreachable—those whose pain is so deep and so profound, and whose lives are so chaotic, that triggering hope for recovery takes assertive and sustained involvement" (p. 64).

5. Peer leadership academy, which trains individuals and family members to assume leadership roles in the communities' recovery focused systems-transformation process.

6. Recovery foundations training, which was provided to agency staff, persons in recovery, community-based service providers, and members of the larger community. This training focused on recovery principles, recovery-oriented care, and the application of the recovery concept in each person's role.

7. A new day: A celebration of recovery, which is a 1-day conference that celebrates the role of peer recovery culture in the Philadelphia community.

8. Storytelling training, conducted for persons in recovery to assist them in telling their stories and boost their confidence in presenting their stories of personal recovery experience and serve as recovery advocates in public venues.

9. The peer specialist initiative, a focused program that, “demonstrates to service recipients, service professionals, and behavioral health leaders the value that experiential wisdom and experienced based skills can add to the service system” (p. 170).

10. The Philadelphia recovery community center, a collaboration between PROACT and the Philadelphia office of addiction services for the delivery of peer-based recovery support services. These centers are bases where life skills education, recovery coaching, recovery plan development, education and employment coaching, family support, parenting training, special interest support groups, sober and leisure activities, and community services projects were delivered.

White’s work provided case studies of some of the more successful peer-based support models and demonstrated that there were significant benefits for peer and volunteer involvement in post-treatment recovery. His review served as the basis for the interviews presented in Chapter 3.

Summary

This literature review focused on three topics pertaining to post-treatment recovery support for alcohol and drugs. The first area of review focused on inpatient treatment for alcohol and drug abuse and the need to better integrate post-treatment services with inpatient services. Secondly, there was extensive discussion of post-treatment support with a key focus on 12-step programs and

the role of peer support in their success. Finally, the review explored the scant literature linking peer review with volunteerism and provided a brief review of the work done by White (2009b) on recovery services, and whose work on peer-based support models shapes much of Chapter 3.

Alcohol and drug treatment programs are critical interventions essential to people suffering from alcohol and drug addiction. After a longer time in treatment, a client is more likely to develop a greater grasp on recovery than after a shorter duration in a facility. The gap between the treatment experience and the home environment could be bridged on both ends by offering more recovery services in the home community and introducing more community support earlier in the institutional setting. Peer support could help the newly discharged patient adopt new values and behaviors that include increased perseverance toward attaining goals, positive attitudes toward others, a renewed positive self perception, self motivation, and a more hopeful outlook toward the future, thus diminishing the potential of relapse.

A common finding of post-treatment research was that the longer the duration of recovery support, whether through formal treatment services or community-based support, the better the recovery outcomes. Studies implied active participation in 12-step programs prior to, during, and after treatment might increase the likelihood of sustained recovery. Key studies in post-treatment success have focused on 12-step programs because the membership participants of 12-step programs voluntarily support fellow alcoholics and addicts. There was strong indication that those who helped others in recovery were strong contributors to their own ongoing recovery as well. Volunteers might help

the newly recovering person create a life with restored meaning and purpose, changed personal behavior, and improved relationships. These individuals also are helped to recognize the personal gifts hidden behind their addictions.

The findings of this literature review suggested that those who help others are much more likely to maintain their own sobriety than those who do not work with others. Consequently, a criterion for volunteer selection is one who models recovery through active participation in 12-step programs. Volunteering to serve a newcomer in recovery is strong aid to the volunteers' own recovery process.

Chapter 3

Methods

The purpose of this research was to determine what treatment providers at alcohol and drug treatment facilities could learn from CBOs about volunteerism as a way to support long-term recovery in a cost-effective way. According to the literature review in chapter 2, a better understanding of volunteerism and peer support as a strategy for extending care beyond a treatment setting has at least two positive outcomes. First, volunteerism and peer support benefits both the treatment center alumni and the volunteers, as research demonstrates that AA members who helped others in recovery were more likely to maintain their own long-term sobriety than those who did not help others. Second, volunteerism and peer support allows a cost-effective way to extend the treatment duration beyond the insulated treatment setting into the home environment, thereby, improving treatment outcomes by reducing the possibility of relapse. A profile sampling of these recovery services delivered by volunteers demonstrated the volunteer impact.

To explore the relationship between volunteerism and peer support, this research has identified recovery support services and volunteer practices from four CBOs and three alcohol and drug treatment facilities. These services and practices were then compared, with the goal of determining which strategies from the CBOs might be valuable for augmenting existing post-treatment recovery curricula. The practical significance of this research was to then develop best practices for alcohol or other drug treatment facilities based upon existing volunteer and peer support strategies among CBOs.

The research had a secondary goal as well. In addition to its practical significance to the recovery community, this original research had academic significance related to better understanding of the benefits of volunteerism to individuals. By investigating the experience of volunteers and peers in the recovery process, this research had the potential to advance our understanding of peer support and volunteerism and the value to both the alumni and the volunteer in helping others in recovery.

This chapter describes the methods used in the study, including the interview protocol, sample, and data collection procedures. Limitations of this study also are identified.

Interview Protocol

The interview protocol for this research was created using a sampling of alcohol or other drug treatment facilities and CBOs. A series of questions was developed for the interviews based upon conversations with treatment providers (see Appendix). These interview questions were intended to identify the specific strategies that represent best practices in peer support delivered by both CBOs and alcohol or other drug treatment programs. The questions were designed to highlight volunteer involvement surrounding the delivery of these programs as well as bring to light the means by which volunteers were supported in their efforts. Interview questions were created to prompt dialogue and were predominantly open-ended in order to access varied responses from the interviewees. The goal of the interviews was to identify volunteers' roles in the delivery of key services and the relevant components offered by the CBOs and alcohol or other drug treatment programs. This information would be used to

determine gaps in recovery programs and develop new strategies based upon the identified features.

Sample

Four CBOs and three treatment programs were selected for the sample in the study. These are described below.

CBOs

CBOs located in the Northeastern United States were selected for the purpose of comparing services rendered to recovering alcoholics and addicts. The CBOs were chosen after the literature review for their noted successes and extensive outreach efforts. Additionally, William White (2008, 2009a, 2009b) who has written extensively on treatment and peer-based recovery support efforts, acted as a subject matter expert and validated these selections. CBOs had the following characteristics:

1. Were concentrated geographically in urban, regional, statewide areas.
2. Offered a wide range of services.
3. Served those with limited resources for treatment and recovery support.
4. Were typically funded by federal, state, and local governments and/or self-funding, with little to no reliance on client fee for services.
5. Heavily emphasized volunteer and peer support which was critical as CBOs generally had limited staffing and financial resources.
6. Exhibited strong coordination with other community social service entities.
7. Focused on a variety of recovery themes related to alcohol and drug addiction.

8. Felt advocacy and public awareness was key.

The CBOs were:

1. The Vermont Recovery Network (VRN), which operates nine recovery centers established for the provision of recovery support services in communities around Vermont. Its primary purpose is helping people find, maintain, and enhance their recovery experience through peer support, sober recreation, and educational opportunities.

2. The Connecticut Community for Addiction Recovery (CCAR), which operates four recovery centers in Connecticut that offer a wide range of recovery support services. CCAR organized the recovery community (people in recovery, family members, friends, and allies) to put a face on recovery and provide recovery support services. By promoting recovery from alcohol and other drug addiction through advocacy, education, and service, CCAR strives to end discrimination surrounding addiction and recovery, open new doors and remove barriers to recovery, and maintain and sustain recovery regardless of the pathway, all the while ensuring that all people in recovery and people seeking recovery were treated with dignity and respect.

3. North East Treatment Centers (NET) is an organization dedicated to providing behavioral health and social services along a continuum of care to adults, adolescents, children, and families in the greater Philadelphia region, Lehigh Valley, and the state of Delaware. NET is a non-profit, licensed, and accredited organization. It provides an integrated continuum of care service system that is quality-driven, cost-effective, and recovery-oriented

4. Pennsylvania Recovery Organization—Achieving Community Together (PROACT) is a grassroots recovery support initiative in Southeastern Pennsylvania (including Bucks, Chester, Delaware, Montgomery, and Philadelphia counties), which works to reduce the stigma of addiction to ensure the availability of adequate treatment and recovery support services and to influence public opinion and policy regarding the value of recovery. PROACT develops, educates, and mobilizes a constituency of Ambassadors for Recovery (recovering persons, their family members and friends, professionals working in the field, and others with a special interest in and knowledge of recovery) who wish to support the recovery community.

Treatment Programs

Representatives from three treatment programs were interviewed to identify peer support and volunteer services and determine volunteer support practices for their alumni. Treatment centers had the following characteristics:

1. Were geographically dispersed across United States with clientele from across North America.
2. Offered primary treatment and specialty programs including, long-term residential treatment, family programs, young adult tracks, gender-specific treatment, relapse prevention, and dual diagnosis.
3. Served clientele that typically had access to resources, including private funding, insurance (in some cases), and occasionally scholarship funds, to pay for services.
4. Were heavily reliant upon patient self-pay as well as philanthropic resources from alumni and others.

5. Hired professional staffing to provide treatment services to those they serve.

6. Served mostly patients from more distant locations and required follow up referrals from treatment staff for continued professional support.

7. Had alumni services programs serving the alumni from these treatment programs. These alumni services staff provided non-clinical support to help alumni stay connected to their recovery, connected to each other, and to their specific treatment program.

The three alcohol or other drug treatment facilities selected were geographically unique, with one each in the Eastern, Western, and Midwestern United States. There was no rating system for treatment facilities; yet, each was held in high regard for providing 12-step principles as a core program modality. Furthermore, each facility had a long service history and maintained a highly regarded reputation industry wide. The three treatment centers were:

1. The Betty Ford Center (BFC), founded in 1982 on the West Coast. BFC declares its mission as providing effective alcohol and other drug dependency treatment services, including programs of education and research, to help women, men, and families begin the process of recovery. It offers gender-focused primary care, extended residential treatment, young adult, and intensive outpatient treatment programs. BFC also provides family and children's programs, chemical dependency evaluations, and sober living facilities.

2. The Caron Treatment Centers, located on the East Coast and founded more than 50 years ago, offers gender-separate, gender-specific treatment programs, including assessments, primary care, relapse, young adult,

adolescent, and extended residential treatment programs as well as programs for families affected by the disease of addiction.

3. Hazelden, located in the Midwest and founded in 1949, states its mission as helping people sustain lifelong recovery from addiction to alcohol and other drugs. Hazelden attempts to accomplish this through a commitment to treatment, publishing, education, research, public advocacy, and shared learning with other organizations. The Hazelden vision is to help all who seek recovery to find it and to overcome the stigma of addiction.

All research findings that follow were derived from these seven entities. In total, seven facilities and organizations agreed to interviews, and 11 staff members answered the interview questions. In some instances more than one person was interviewed at an agency. The numbers are displayed in Table 1.

Table 1

Research Census Grid

Organization	People Interviewed	Hours per interview
Virginia Recovery Network	1	2.50
Connecticut Community for Addiction Recovery	1	1.75
North East Treatment Centers	3	0.5-0.75
Pennsylvania Recovery Organization—Achieving Community Together	1	3.00
Hazelden	1	1.50
Caron	3	1.00
Betty Ford Center	1	2.00

Data Collection

The 12 interviews were primarily conducted face-to-face. On two occasions, staff members from two treatment facilities were surveyed by telephone. In addition to interview data, the study author provided complimentary data from the BFC based upon the author's personal experience with that facility,

where he served as vice president of alumni services since 2002, and had been intricately involved developing the alumni services volunteer program and alumni support efforts. Two staff members then validated the BFC data for accuracy and objectivity. Each of those interviews lasted approximately 1 hour.

The study author conducted the interviews with an independent research assistant who recorded notes. The study author also took notes during the interviews. In addition, an electronic version, using a tape recorder, was generated to ensure further accuracy of the information.

Five of the interviews were conducted over 8 days in January 2010. A large quantity of information was gathered, so it was decided to develop a customized system to categorize and code incoming data. A matrix of the major categories of information derived from the interviews was created. The data were extracted and then placed in the matrix for ease of display and analysis. At the end of each day, the research assistant transcribed notes independently in the matrix utilizing key categories and applying relevant detail beneath each heading. The study author then dictated his findings from handwritten notes to the research assistant who transferred the information into the matrix format. It should be noted that the study author did not review the independent recorder's notes until after conducting his assessment of the information gathered in the interviews. This process allowed for agreement and validation.

The independent research assistant extracted further data by listening to the recordings of the interviews to ensure completeness and accuracy. Additional details from the electronic recordings were included in the matrix format under the designated categories. Archival material that further illuminated the programs

was examined in greater depth. This material was collected from printed materials and handouts that each agency provided after the interview was conducted. Further research was conducted by review of agency websites and other collateral material.

A third level of data refinement was conducted by additional research assistants in order to condense material and eliminate repetitive content. Next, a color-coded outline matrix was designed to ensure the research results were specific, relevant, and organized. The matrices began to take shape within major categories headed by prevalent themes. When applicable, a second round of analysis was carried out by taking each major category and dissecting it further into more specific subsets under the major headings. Subsequently, a third round was conducted to further highlight and extract additional detailed information for analysis. Finally, a narrative outline and the tables of research data were sent to each interviewee for final verification. A phone discussion followed, with five interviewees of the seven agencies interviewed, to verify research findings in their respective organizations.

Limitations

The primary limitations of the data presented here reflect the interview methodology itself: interviewer bias. As with other qualitative methodologies, the study author was, in many ways, the interview protocol as well as the vehicle by which the interviews were conducted. The questions were derived from conversations with industry professionals known to the study author, and many interviewees were familiar with the study author's professional position either personally or through professional reputation. Therefore, the quality of the data

may be influenced by participant opinion of the researcher such as credibility and reputation. As such, the data collection methods cannot be replicated scientifically as they are intimately linked to the study author's personal network and professional experience doing interviews.

An additional limitation to the methodology was the lack of transcription of the recorded interviews, although the electronic recording device all but guaranteed the accuracy of the findings for the matrix. It was determined that transcription would be an unnecessary expense of the research. The qualitative methods were intended to identify meaningful and useful results and findings rather than elicit verbatim information, data, or findings.

In sum, the methodology was almost exclusively qualitative and intended to identify meaningful volunteer strategies and elements supporting recovery across seven organizations. Therefore, the interview protocol was used as a guideline to shape the face-to-face interviews rather than as a set of predetermined questions. While these methods result in some data limitations, they were determined to be the best strategies for eliciting the necessary information to make meaningful recommendations on the role of peer support and volunteerism in post treatment activities for drug and alcohol treatment centers.

Chapter 4

Research Findings

The purpose of the research was to investigate ways that CBOs and treatment centers utilized volunteers and peer support to extend the benefits of alcohol or other drug treatment beyond the clinical setting. Because the risk of relapse from drug and alcohol recovery could be reduced by lengthening a client's exposure to 12-step meetings and interaction with recovering people, the benefits of extending treatment into a client's home environment beyond the typical 30-90 day treatment center stay could be significant. This study explored whether the use of volunteers and peer support among CBOs might offer a cost effective and meaningful way for treatment centers to extend their services beyond the treatment setting.

These research findings were derived from 11 face-to-face interviews with the staff from four CBOs and three alcohol and drug treatment centers, described in detail in chapter 3. At first glance, it became clear that there were some important qualitative differences between CBOs and alcohol and drug treatment centers. This research explored how these differences were meaningful for extending the benefits of alcohol and drug treatment through volunteer utilization and peer support. It also provided important findings about the reasons that volunteers are so committed to recovery service provision.

Differences Between Treatment Centers and CBOs

Treatment centers differed in many ways from CBOs (see Table 2). For instance, they were generally not located in the client's community. They provided isolation and insulation from family or community pressures during the

initial recovery experience. As noted throughout this work, the transition from the treatment environment to the home community presented one of the most immediate challenges of treatment sustainability. Because the treatment centers utilized a medical model, they were generally more costly, shorter in duration, and relied almost exclusively on professionals.

Other differences between CBOs and treatment centers included differential reliance on volunteers. Treatment centers expended very limited, if any, resources on volunteer training and management. Treatment centers also utilized volunteers in more limited ways than CBOs. That is, the volunteers were not involved in the same scope, quality, or level of service in treatment centers as they were in CBOs. Rather, more of the work was done by professionals in the recovery or medical field, making the treatment center methods more costly and shorter in duration than the services provided by CBOs.

Table 2

Differences Between Treatment Centers and Community-Based Organizations

Community-Based Organizations	Treatment Centers
Located in the client's community	Located away from clients' homes
Featured more integration with recovery and environment	Involved transitional challenges when clients returned home
Dedicated significant funds to volunteers	Dedicated fewer funds to volunteers
Used volunteers as the frontline of the recovery squad	Did not use volunteers to provide services
Used trained volunteers as recovery coaches	Used professionals to delivery recovery work
Provided a wide variety of services	Provided focused modalities
Used a social model	Used a medical or acute care model
Offered long-term programs	Offered short-term programs
Were cost-effective	Were expensive and exclusive
Believed volunteers were recipients and also gave back	Believed volunteers were helped by helping

Goal Similarities: Differences in Delivery

While the research demonstrated that CBOs and treatment centers differed in meaningful ways, they also shared important goals. Given their shared interest in facilitating healthy lifestyles and families, these organizations sometimes offered similar programs, even if in different ways. For example, all agencies interviewed offered some level of ongoing family program and family inclusion using peer support facilitators. These support programs included education, parenting skills, recovery tools for family members, self-nurturing, and esteem building.

Volunteers at treatment centers were motivated in similar ways to those in CBOs, as they also reported important sobriety “kickbacks” associated with working with others in recovery (i.e., helping others helps the helper). Staff in both types of organizations shared that the volunteers personally benefited from helping others and saw their role transition (from recipient to volunteer alumni) as the act of taking their place in the recovery community. This research suggested that there were important incentives for better understanding the ways volunteers experience the benefits of volunteerism and encouraged future research on that topic.

Not surprisingly, CBOs tended to rely more heavily on peer support for their family-oriented programs. Table 3 displays the ways each CBO approaches family support. For example, peer facilitators led the VRN Nurturing Parents Program, which taught age appropriate parenting skills. Peer facilitators were trained by Prevent Child Abuse Vermont. Both peers and professionals facilitated The Rocking Horse Circle of Support, which provided interventions for mothers

aged 18 to 35 years. Peers and professionals also facilitated Wits End parent support groups for people whose children are in trouble with alcohol and drugs. These programs were offered in many of Vermont's recovery centers.

Table 3

Community-Based Organization Family Support

Community-Based Organization	Family Support
Vermont Recovery Network	<ul style="list-style-type: none"> • Nurturing parents program: led by peer leaders who had been trained by Prevent Child Abuse Vermont • Rocking Horse Circle of Support: group intervention for mothers 18- to 35-years-old. • Wits End parent support group: helps parents and children in trouble with drugs and alcohol
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • Family night: alcohol and drug addiction education and support program for members of the recovering community, people in recovery, and their families.
North East Treatment Centers	<ul style="list-style-type: none"> • Family inclusion: invited a key supporter in the family to join special sessions. • Family-focused behavioral health services: a team comprised of a lead clinician, case manager, and crisis worker that provided support to families in the home, school, and community.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Family program: offered in each of its eight centers in southeast Pennsylvania each month. This three-session series also offered ongoing access to education, skill building, communication, how to not enable, and more.

Similarly, CCAR offered Family Night, an alcohol and drug addiction education and support program for members of the recovery community, their family, and their friends. NET offered Family Inclusion programs and sessions for education and support. PROACT provided a three-session family program with ongoing education in skill building, learning how to not enable, and improving communication skills. These sessions were held monthly at each of PROACT's eight centers throughout southeast Pennsylvania, for a total of 24 sessions each month.

Family recovery services at the treatment centers, while highly effective, were largely run by professionals in a treatment setting and were of a limited duration. Additionally, the number of family members that could be exposed to family services at a treatment center might be limited. As patients at treatment centers were generally not residents of the local community, their families sometimes were limited by travel constraints and other factors such as cost and professional availability. Similar to CBO programs, ongoing post-treatment family support by treatment centers was offered through alumni recovery support groups, participation in workshops, retreats, social events, and anniversary weekends. Family members also served as volunteers in some treatment alumni programs.

By now, it is clear that CBOs and treatment centers shared similar goals but utilized different strategies. This chapter presents specific findings from original research on these differing methods and elements for extending the benefits of alcohol and drug treatment beyond the formal treatment setting. In particular, these findings highlighted contrasting ways that CBOs and treatment centers allocated organization resources to the development and management of volunteers and utilization of volunteers within the organization. They also differed in terms of the scope and quality of services offered by volunteers. A critical finding was that in spite of the differences in these qualitative factors, the underlying motivation for volunteerism in both types of organization was largely the same.

Motivations for Volunteerism

Recognition events for peers and persons in recovery were important for the CBOs, which depended upon significant volunteer support. A summary of methods CBOs used to recognize volunteer efforts can be found in Table 4.

Table 4

Community-Based Organization Volunteer Recognition

Community-Based Organization	Volunteer Recognition
Vermont Recovery Network	Honored and recognized volunteers. Offered volunteers good supervision, clear roles, job description, and recognition events.
Connecticut Community for Addiction Recovery	Annual volunteer recognition fundraising dinner recognized volunteers for their time and commitment.
North East Treatment Centers	Recovery recognition day included monthly client events and an annual banquet.
Pennsylvania Recovery Organization—Achieving Community Together	Recognition dinners celebrated volunteer service. Monthly recognition was recorded on calendars to indicate who was participating in monthly events. Monthly training was provided to volunteers to provide professional certification

To show its appreciation, VRN held regular recognition and celebration events acknowledging the significant efforts and impacts of volunteer support. CCAR hosted an annual volunteer recognition fundraising dinner where volunteers were acknowledged for their time and commitment. The volunteers with 100 or more hours were presented with an award certificate signed by the President of the United States. The NET hosted monthly volunteer and recovery recognition banquets, where speakers shared stories about recovery and what had inspired them. Clients received recognition certificates and the dinner was followed by sober leisure activities.

While volunteers were not as central to their operations as they were to CBOs, treatment centers recognized that volunteers served an important role in their programs and to support the ongoing recovery of fellow alumni. Given their

important role, treatment centers gave consideration to volunteers in return for their service. For example, BFC volunteers were offered recovery workshops and programs sponsored and sanctioned by the center, at low to no cost in recognition of their efforts. These programs included relationship enrichment, relapse prevention, codependency, family, spirituality, meditation, and trauma recovery programs. Alumni services staff offered support to manage and develop volunteers one-on-one and in group settings with an emphasis on community building among volunteers. The alumni services staff also coordinated events for alumni volunteers, including semiannual gatherings that focused on improving service delivery and anniversary events.

While the recognition of their services was an important activity, those interviewed from the seven organizations reported that most volunteers in both the CBOs and treatment centers shared that the volunteers' greatest reward for service was their own continued sobriety. These research findings suggested with both practical and academic significance that the motivation for volunteerism was similar across the types of organizations (despite the organizations' other differences). Rather, volunteers in all settings were clear that they understood they were part of a larger recovery community wherein they transition from recipient to volunteer and where helping others became a key practice for their own recovery.

These volunteers and peers played a critical role in extending the benefits of treatment beyond the formal setting. This research demonstrated that CBOs had much to share with treatment centers regarding the return on investment for training, managing, and rewarding volunteers. There was a clear social and

recovery incentive for better understanding the role of volunteerism and increasing volunteer utilization in recovery settings. Additionally, the cost efficiency of using volunteers provided an important motivation for treatment centers and other organizations to further explore this promising strategy.

Commitment of Resources to Volunteers

One finding was that CBOs allocated a significant portion of their resources to training, managing, and supporting volunteers. This was essential because volunteers provided the bulk of services at CBOs. Extensive training was thus provided to these workers to enhance their capacity to serve their peers. These volunteers served on the frontlines of recovery support and were heavily utilized in service provision. Volunteers often were trained as recovery coaches and performed a wide variety of services, from facilitating recovery group meetings and holding workshops on developing basic life skills to facilitating specialized programs. These volunteers were community members committed to the long-term health of the client, family, and community at the grassroots level. CBOs represented a social model for recovery support that was both cost-effective and sustainable, as it was located in the client's home community and could, therefore, be integrated into his or her life system.

CBO volunteers were motivated by a host of incentives, but the majority of those interviewed stated their volunteers' primary motivation for helping others was that it helped the *volunteer*. This sentiment was closely tied to the fact that many volunteers were once themselves recipients of CBO services and saw themselves as giving back to the very organizations that allowed them to recover and succeed.

CBO Volunteer Training

Volunteer training commitments were of significant duration, cost, and intensity in CBOs due to the central role of volunteers in recovery support services. Various CBO approaches to recovery coaching and leadership training are outlined in Table 5. For example, VRN provided education and career classes on computer skills, reading and study skills, general educational development (GED) certification, resume writing, and personal planning. CCAR had committed to volunteer training and hosted the Recovery Coaching Academy, a 5-day training session for recovery coaches that developed participants' skills as a hybrid between 12-step sponsorship and case management. Topics included sponsorship, mentoring, coaching, and development of personal recovery plans. Participants were trained to lead peer resource connector programs and life skills workshops. Leadership development classes and workshops further increased participants' personal development through communication, conflict resolution, cultural competency, ethics, facilitation, and group process skills.

Additionally, NET developed the peer mentors concept to establish relationships with their consumers. A part of the peer mentors' role was to promote continued participation in treatment and offer empathy and support. PROACT provided a Peer Leadership Academy for their peer leaders who provided social support services to individuals at all stages of the recovery process. Peer leaders were given skill sets to talk about tipping points and quality decision making. PROACT conducted a leadership training called champions of recovery, where volunteers were trained as leaders to put a positive face on

recovery. They organized by zip codes and exchanged information by interfacing with the public, such as police officers, councilpersons, and media broadcasts.

The volunteers' purpose was to inform communities that recovery resources were available. Volunteers also served on boards, committees, and task forces.

Table 5

Recovery Coaching and Leadership Training in Community-Based Organizations

Community-Based Organization	Recovery Coaches and Leadership Training
Vermont Recovery Network	See Table 7 on page 44
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> Recovery Coach Academy: 5-day training developing participants' skills as a hybrid between 12-step sponsor and case manager, highlighting one-on-one roles of recovery coach (ally, confidante, truth teller, and community resource broker).
North East Treatment Centers	<ul style="list-style-type: none"> Peer mentoring: helps mentors demonstrate responsible concern for themselves, others, and the community. Includes training to establish relationships with other consumers, promote participation in treatment, and offer empathy and support.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> Peer Leadership Academy: trained volunteers as leaders to put a positive face on recovery and provided a skill set to talk about tipping points, quality decision making, and interactive and project-based curriculum. Champions of Recovery (after leadership training): Helped volunteers organize by zip codes and neighborhoods to let the community know that recovery resources were available. Talks and information given by police officers, councilpersons, and media broadcasts. Volunteers served on local boards, task forces, and committees in the communities. Recovery Coach Training I, II and III: provided training and support for individuals to identify relapse triggers and provide skill building that correlate to the relapse trigger. Recovery coaches work one-on-one to develop a partnership focused on personal growth. The relationships were strength-based and goal-oriented.

Because they relied so broadly and deeply on volunteerism, many CBOs developed a comprehensive training system incorporating varied levels of training support for their volunteers. A mid-level training series was offered by many organizations to volunteers who advanced in their service commitments. For example, CCAR offered a recovery training series that helped volunteers build recovery capital (a greater understanding of addiction and recovery) tools

for assisting persons to clean up their past problems, and information on opening a recovery house.

Some training was more formal than others. NET offered peer specialist training to certify peer specialists. These training curriculums offered insight into mental disorders, oriented volunteers to their organizations' policies and procedures, and paired volunteers with mentors. Volunteers also received training in ethics, boundaries, professional conduct, and appropriate work attire. PROACT provided Certified Recovery Specialists training to help volunteers provide non-clinical in-house recovery planning. This training was provided by the State of Pennsylvania. These peer specialists provided social services to individuals at all stages of the recovery process. Table 6 summarizes CBO certification and specialist training.

Table 6

Certification and Specialist Training at Community-Based Organizations

Community-Based Organization	Certifications and Specialist Training
Vermont Recovery Network	See Table 7 on page 44
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • Recovery training series was aimed toward building recovery capital.
North East Treatment Centers	<ul style="list-style-type: none"> • Certified recovery specialists were provided. • Assessment training was provided. • Certified peer specialists offered insight into mental health disorders.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Certified recovery specialist training was provided. • Peer leaders (provided by the State of Pennsylvania) provided social services to individuals at all stages of the recovery process. They provide skill building, facilitate Saturdays at the Center and oversee workforce development projects in their neighborhoods.

As a result of their extensive training, volunteers made significant time commitments to CBOs. For instance, in 2009, VRN volunteers provided more

than 30,000 hours of service combined at recovery centers across Vermont.

These volunteers greeted and served visitors to their centers, provided resource information, and helped clean the facilities. Volunteers also supplied recovery training solutions for newcomers to determine where they were in their recovery process, provided encouragement, and urged them to ask questions. Volunteers learned to establish rapport with clients and helped create connections that led clients to employment, housing, and other social services. VRN also conducted volunteer training workshops to develop listening skills, conflict resolution skills, commitment to confidentiality, data collection skills, empathic relationship skills, and the ability to assess visitors' interest in recovery through motivational interviewing.

Similarly, CCAR volunteers annually provided tens of thousands of volunteer hours in centers in Connecticut. Volunteers gained an understanding of the CCAR mission and history and conducted the volunteer orientation, called CCAR Ambassador 1, which focuses on values, ethics, and the foundations of advocacy in recovery. NET developed their Consumer Council by focusing on developing values and behaviors that promoted recovery. They provided service opportunities that helped maintain meaningful recovery experiences and strengthened self-worth. These experiences helped each participant discover their own unique resiliency.

Similarly, PROACT enlisted help from recovery support volunteers to listen, educate, and refer those in need of further assistance to the most appropriate resources. Using 300 volunteers, PROACT served 15,450 people in all activities in 2009, including 1,000 families. The recovery centers provided

support to 10,950 people. The planning of the annual Recovery Walk consisted of seven committees with combined 40 volunteers on the committees. PROACT also conducted Foundations for Volunteering I and II. Part I identified the strengths of volunteers, the reasons why people volunteer, understanding volunteer opportunities, understanding the brain disease, boundary setting, and recovery support services. Part II focused on communication, confidentiality, and solution based relationships. Table 7 outlines CBO volunteer training fundamentals.

Table 7

Volunteer Training Fundamentals in Community-Based Organization

Community-Based Organization	Fundamentals
Virginia Recovery Network	<ul style="list-style-type: none"> • Special volunteer structure provided 30,000 volunteer hours toward recovery support services at centers across Vermont, serving visitors to the center. • Recovery training solutions helped newcomers identify where they were in their recovery process, provided encouragement, and urged them to ask questions. • Volunteer training workshops focused on listening skills, conflict resolution, confidentiality, and data collection as well as developing empathy, assessing visitors' interest in recovery, and conducting motivational interviewing.
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • Volunteer Orientation Ambassador 101 focused on values and ethics, the nuts and bolts of advocacy in recovery. It also improved understanding of the organization's mission and history.
North East Treatment Centers	<ul style="list-style-type: none"> • Consumer council improved values and behavior that promote recovery and increased each consumer's responsible concern for themselves, others, and the community.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Recovery support volunteers worked to listen, support, educate, and refer those in need of further assistance to the most appropriate resources. • Foundations for Volunteering I & II course: Part 1 focused on Identifying strengths as volunteer, reasons why people volunteer, understanding volunteer opportunities, and recovery support services. It also worked on understanding brain disease and boundaries. Part 2 focused on communication, confidentiality, and solution-based relationships. • Recovery support volunteers were a trained network of volunteers who were able to listen, support, educate, and refer those in need to the most appropriate resources. They were trained in skill building, recovery management, and supporting individual recovery plans.

Treatment Center Volunteers

Treatment centers committed a smaller percentage of their organizational resources to training, managing, and rewarding volunteers. They also utilized volunteers in qualitatively different ways than CBOs. Treatment centers were more likely to utilize an acute care model that relied more on professionals than on volunteers. Therefore, volunteers generally carried out secondary roles rather than serving on the frontlines of recovery support.

While not as central to inpatient treatment service delivery as a CBO, the BFC utilized a group of local volunteers to provide peer support to patients at the center for a variety of services. At BFC, volunteers and alumni led multiple 12-step meetings for patients and facilitated a “Back to Basics” program which encouraged patients to take all 12 steps. Volunteers also provided lectures to patients on the 12 steps, entry into the 12 steps, and sober fun and leisure. Patients could request visitation by an alumni on Sunday afternoons. Alumni volunteers also visited the residence halls on holidays to facilitate arts and craft events or even to decorate the halls for holiday celebrations. Caron volunteers, under the direction of a volunteer coordinator, welcomed patients during the admissions process, talked with new admissions during detoxification, and provided onsite and offsite transportation for appointments and 12-step meetings off campus. Six nights a week, Hazelden alumni shared their experience, strength, and hope (the primary form of peer support, as used in AA, versus advice giving) and hosted Pass it On, a meeting that allowed alumni to share how they stayed sober right after discharge. The alumni volunteers also

facilitated a weekly AA orientation. Table 8 outlines alumni peer support roles in treatment centers.

Table 8

Treatment Center Alumni Peer Support in Treatment

Treatment Center	Alumni Peer Support in Treatment
Betty Ford Center	<ul style="list-style-type: none"> • Local alumni offered multiple services to support patient in treatment. • Offered 12-step meetings, including gender-specific meetings. • Held question-and-answer panels. • Facilitated “Back to Basics” and all 12-steps programs. • Delivered patient lectures on the 12 steps, AA, and life after recovery. • Offered sober leisure activities. • Offered one-on-one patient visitation each Sunday as requested. • Hosted holiday celebrations with alumni. Activities included arts and crafts, seasonal residence decorating, conversation, and celebration.
Caron	<ul style="list-style-type: none"> • Caron volunteers (not from the alumni department) welcomed patients in admissions, talked with newly admitted clients during detoxification, and provided onsite and offsite transportation for appointments and off-campus 12-step meetings.
Hazelden	<ul style="list-style-type: none"> • Alumni on the main campus shared experience, strength, and hope 6 nights a week. Alumni also hosted Pass it On meetings and weekly AA orientations.

The BFC regional alumni volunteers operated as a service group, not as a decision-making entity. The organization was structured horizontally and informally, operating on the recovery principles of service to others. The regional alumni volunteers were gaining autonomy through leadership training and empowerment through experience. A semi-annual volunteer gathering was hosted at the center. This forum allowed regional alumni volunteers to share experiences of recovery as well as to build community and capacity within the individuals and the group.

Alumni volunteers at BFC were trained to facilitate workshops such as Back to Basics and grief recovery programs to serve alumni in their home communities. Caron had its National Alumni Leadership Council that served at the direction of the alumni relations. The council met twice a year and helped

coordinate functions within their respective regions. Hazelden operated with 500 volunteers across all its sites, who dedicated more than 10,000 hours of service annually. The alumni served as alumni contacts, speakers, event volunteers, and organizers. Table 9 summarizes the volunteer structure utilized at the treatment centers.

Table 9

Treatment Center Volunteer Structure

Treatment Center	Volunteer Structure
Betty Ford Center	<ul style="list-style-type: none"> • Volunteers functioned as a service group and not a decision-making entity. • Volunteers hosted semiannual volunteer gatherings for recovery support, community building, and information sharing. • Volunteers provided regional support on an as-needed basis. • Volunteers trained to facilitate grief recovery programs, Back to Basics, and 12-step workshops. • Volunteers were offered low-cost and no-cost admission to recovery enrichment programs such as codependents anonymous, couples/relationship enrichment, and relapse prevention. • Alumni services staff helped coordinate events for volunteers. • Alumni services staff managed volunteers and developed support as needed.
Caron	<ul style="list-style-type: none"> • The National Alumni Leadership Council operated under the direction of the alumni relations department. The council met two times a year.
Hazelden	<ul style="list-style-type: none"> • Hazelden operated with 500 volunteers across all its sites, who dedicated more than 10,000 hours of service annually. The alumni served as alumni contacts, speakers, event volunteers, and organizers. An alumni leadership committee was being formed in 2010 at each regional location to help advise Hazelden, plan activities and events, and create new service opportunities.

Volunteers were vital to success for the newly discharged alumni of the treatment centers who must return to their home environment. Volunteerism offered opportunities for the volunteers to be of service, give back to the entity they held in deep gratitude, and receive reinforcement for their own recovery.

Utilization of Volunteers: Scope

CBOs provided vital services and effectively used volunteers and peer support in the delivery of these programs. This research revealed a number of high-impact services that rely on volunteers. The VRN hosted peer-led post-

traumatic stress syndrome groups, based on Seeking Safety, a 25-week step-by-step, peer-facilitated process. This program was facilitated through dialogue, witnessing conversation, creating new possibilities, and holding space for the process. Seeking Safety was a present-focused support to help people attain safety from traumatic events in their lives. These sessions were conducted in individual and group structured formats for women, men, and mixed gender forums. The VRN also hosted life skills workshops aimed at helping clients with financial management, nutrition, parenting, relationship skills, and citizen restoration. Health and Wellness programs were presented that addressed relapse prevention, stress management, smoking cessation, yoga, and reproductive health. Non-violent communication groups and practices were a common denominator in recovery centers. Wellness recovery action plan groups also provided support for individuals, recovery plans, and a group process for problem solving and sharing successes. VRN's recovery centers also hosted peer-led recovery planning groups, which helped participants look at their personal recovery goals.

NET offered peer specialist groups for supporting clients in overcoming the desire to dropout of treatment. One way NET discouraged relapse was to recruit volunteer speakers who shared their own personal recovery story and provided hope in recovery. This re-engagement program was intended to increase motivation for engagement in the treatment program. The program also provided education and modeling about the act of sharing and the activities of group process in treatment and recovery. The staff and volunteers played a powerful role as models of recovery behavior. NET also provided wellness

recovery action plans to clients for customized support to meet their specific needs. For example, NET offered free care groups led by peer specialist facilitators to allow clients to receive recovery support when insurance lapses. The peer specialists provided social support in every element of service and were an integral part of each recovery client's experience.

PROACT provided social support services to individuals at all stages of the recovery process. Similar to VRN, PROACT provided support through life skills workshops such as personalized recovery plans, wellness recovery plan groups, health and wellness workshops, and health prevention programs. In addition, they provided sessions focused on AIDS, smoking cessation, and diabetes. Peer-to-peer support naturally evolved with PROACT, which started with the formation of recovery communities. Table 10 outlines specialized recovery workshops and programs offered at the CBOs.

Because many recovery challenges related to family roles and expectations, gender-specific programs were offered by most CBOs. VRN's centers offered a number of groups for women. There was a woman's writers group and safe talk for women group held the Brattleboro recovery center. Women act was a peer-facilitated, woman-specific recovery group in the Bennington recovery center. Mothers in recovery groups were held at the Burlington recovery center. CCAR offered the women in recovery enhanced design group that connected women in the community with art projects and other community services. NET offered a women's trauma recovery program. According to their model, women were taught to view themselves in more positive ways and were guided in building self-esteem and self-confidence in

Table 10

Specialized Recovery Workshops and Programs Offered at Community-Based Organizations

Community-Based Organization	Specialized Recovery Workshops and Programs
Virginia Recovery Network	<ul style="list-style-type: none"> • Seeking Safety Present was a peer led, facilitated group process to help people attain safety from Post Traumatic Stress Syndrome and trauma using 25 step-by-step session formats. • Life skills workshops & Non-Violent Communication sessions were available. • Health and Wellness promotion programs and workshops on diet and smoking cessation also included referrals to medical support. • Personalized recovery plans, wellness recovery action plan groups, and recovery planning groups were available.
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • All recovery included meetings, for men, women, and mixed gender. • A peer support group for those going through hepatitis treatment was available. • A talk employment support group was available. • Recovery asset mapping project helped build relationships in the local community, inventory skills and interests of individuals, and set up appropriate and healthy connections.
North East Treatment Centers	<ul style="list-style-type: none"> • Alumni groups were run by peer specialists engaging in the transformation of recovery. Peer support and prevention of treatment dropout was the goal. • A re-engagement program increased motivation and engagement in treatment and workforce/life skills program. • A recovery action plan and wellness recovery action plans were available. • Free care group was for instances when insurance lapsed; treatment was continued with the help of peer specialist's support throughout the curriculum. • A peer specialist program was involved in nearly every function that took place and was an integral part of each new recovery experience.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Peer facilitators provided social support services to individuals at all stages of the recovery process. • Life skills workshops were available. • Personalized recovery plans and wellness recovery plans groups were available. • Health and wellness workshops were available. Health prevention programs also were available. • AIDS, smoking cessation, diabetes information was available. • Recovery asset mapping project helped build relationships in the local community, inventory skills and interests of individuals, and set up appropriate and healthy connections.

their ability to recover from the effects of past trauma and substance dependence. In addition to accepting a lack of control over addictive chemicals, women learned how to develop and use a personalized recovery plan. PROACT offered women's life skills through the women's center in Bucks County as well as recovery support workshops, workforce development, a dinner Bible study group, journaling, and the option of a residential recovery house component.

Table 11 summarizes women's recovery support at various CBOs.

Table 11

Women's Recovery Support Offered at Community-Based Organizations

Community-Based Organization	Women's Recovery Support
Virginia Recovery Network	<ul style="list-style-type: none"> • Held woman's writers group and safe talk for women in the Brattleboro recovery center. • Held women act, a peer-facilitated, woman-specific recovery group in the Bennington recovery center. • Held mothers in recovery groups at the Burlington recovery center.
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • Women in recovery enhanced design group helped women transition into the community.
North East Treatment Centers	<ul style="list-style-type: none"> • Offered women's trauma recovery program in Philadelphia. Focused on empowering women and helping them recognize the unique histories of trauma that led them to abuse and become dependent on substances.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Women's recovery centers supported women in healthy relationship building, managing money, cooking for recovery, job readiness, resource connections, and medication management. The women learned life skills and received recovery support. There was also a women's recovery house with a residential component.

Because CBOs served a unique social purpose in their communities relative to private treatment centers, they were tasked with larger grassroots activities. For example, raising public awareness about addiction and reducing the stigma of recovery were essential goals of many CBOs. They offered media workshop training and shared stories of recovery to influence citizens,

legislatures, and those currently struggling with addiction. CCAR offered media training workshops to introduce new addiction language and provided instruction and practice using this language with media and other speaking engagements.

Table 12 describes CBO advocacy and community outreach methods. VRN used recovery centers as advocacy platforms where recovery concepts were woven into the fabric of services offered in the community by providing visible and tangible advocacy and benefits. VRN also developed community-based partnerships with The United Way, Chambers of Commerce, Drug Courts, and other local coalitions. CCAR sponsored recovery walks to heighten awareness. PROACT provided peer leadership training and mobilized *recovery captains* by neighborhood to heighten awareness about prevention, treatment, and recovery support among legislatures and council persons.

Several other unique and powerful programs of note emerged from the research on CBOs. For example, VRN recovery centers, along with several other CBOs, had piloted a program entitled “Making Recovery Easier.” It was based on the researched model “Making Alcoholics Anonymous Easier” developed by Kaskutas and Oberste (2002). Several CBOs were delivering the curriculum according to the researched protocol but had changed the name to avoid confusion about affiliation with AA when it was delivered in a recovery setting. The groups provided a process for participants to develop a personal path to recovery. Topics included spirituality, sponsorship, and sober living. It also addressed myths about AA, Narcotics Anonymous, and Cocaine Anonymous. This program was designed for those new to recovery and for those having difficulty with maintaining recovery and the spiritual aspects of 12-step programs.

Table 12

Advocacy and Community Outreach in Community-Based Organizations

Community-Based Organization	Advocacy and Community Outreach
Virginia Recovery Network	<ul style="list-style-type: none"> • Wove recovery concepts into the fabric of services offered in the community. • Instrumental direct support included child care, transportation, clothing services, and food banks.
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • Delivered the Recovery is Possible media workshop with the goal to influence citizens, legislatures, and those with addictions. • Operated Winner's Circle-Inner Circle, a program in which ex-offenders in recovery (Winner's Circle) take meetings to people in the jails (Inner Circle). • Recovery housing developed standards for sober living houses and created a web presence for easier access to sober living. • Recovery walks heightened public awareness of recovery resources.
North East Treatment Centers	<ul style="list-style-type: none"> • Responsible concern emphasized care of self, care of the centers, and care for the community. It also built a positive structure for free time. • Frankford Clean Up was the longest standing outreach program at the organization. It cleaned up neighborhoods by removing drug paraphernalia and beer bottles in a 10- to 12-block area. • Outreach teams focused on individuals with chemical dependence and substance abuse problems in drug-infested areas. Teams handed out flyers and found users on the street to offer support. • Move In, Move Out used volunteers to go to drug-infested areas of the city and walk the addict to treatment. • Outreach Orientation provided a detailed script of recovery do's and don't's. Volunteers were instructed on the intake process. • Youth Intervention Prevention Program was a way for peer youth to leverage their influence and encourage others to follow a healthy path in a positive direction. • Speaker's Bureau was an opportunity for peer consumers to share their knowledge and experience with substance abuse in the community.
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Recovery Walk was a highly visible recovery celebration that honored individuals and families in recovery, provided recovery-focused education within the wider community, and advocated pro-recovery social policies and programs. • “Philly's Got Recovery” was a monthly media event with a press release spotlighting special events and special topics (homelessness, restoring credit, returning veterans, etc.) in each of the eight centers. • Champions of Recovery allowed volunteer leaders to put a positive face on recovery, and be active in their neighborhoods, and let their communities know that recovery resources were available. • Citywide Martin Luther King day included neighborhood outreach programs that informed and built recovery resources in the community. • A New Day celebrated the growing role of the peer recovery culture and the transformation of Philadelphia's health care system.

CCAR created the Legacy of Hope-Recovering Elders Project, which was the creation of a compelling documentary of people with ultra long-term sobriety. This documentary was a 30-minute digital video of interviews with elders, family members, friends, photos of the elders' life and supporting documents, and B-roll footage of places of interest to the elder's life.

Another powerful program, the Tree of Hope annual holiday project, which was initiated by PROACT, and celebrated recovery, demonstrating that recovery was possible. This honoring was initiated by decorating an evergreen tree with personalized ornaments commemorating these individuals during the holiday season. Individuals who were in recovery were honored, and there was recognition of others currently in recovery. They were also honored by family members. The Tree of Hope also recognized and showed appreciation for all who supported recovery such as sponsors, coaches, families, and providers of recovery services. The event also recognized those who had lost their lives to addiction and acknowledged that the life was not lived for naught. This annual public holiday recognition was held at the courthouse in Bucks County. It also demonstrated to those who have family in the criminal justice system that there was hope.

PROACT also sponsored a story-telling training called Take it to the Streets. Training was offered to recovering persons, encouraging them to share their hopeful recovery stories in a compelling way. The hope was that a participant would encourage others toward recovery and become a face and voice of recovery with positive influence within their community. Table 13 lists these unique CBO programs.

Table 13

Unique Programs Offered by Community-Based Organizations

Community-Based Organization	Unique Programs
Virginia Recovery Network	<ul style="list-style-type: none"> • Making recovery easier program was based on the Making Alcoholics Anonymous Easier program.
Connecticut Community for Addiction Recovery	<ul style="list-style-type: none"> • Legacy of Hope: Recovery Elders Video Project was a video documentary format of the lives and recovery stories of people with ultra long-term sobriety.
North East Treatment Centers	<ul style="list-style-type: none"> • See Table 11 on page 51
Pennsylvania Recovery Organization—Achieving Community Together	<ul style="list-style-type: none"> • Tree of Hope recovery celebration demonstrated that recovery is possible. This was a public annual recognition of decorating an evergreen with personalized ornaments to symbolize people in recovery and those who had lost their lives to addiction. Its goal was to demonstrate hope to families of those who were in the criminal justice system. The Tree of Hope also recognized and showed appreciation for all who support recovery, such as sponsors, recovery coaches, providers, and family members. • Offered Take it to the Streets, a story-telling training class to help people write and share their compelling stories of recovery as positive influences in the community.

Alumni Services for Treatment Centers

Since treatment centers were short in duration and required that alumni return to their home environment after a period of time, it was vital to support clients' transitions home. The BFC attributed its primary success to the work of nearly 90 regional alumni volunteers from across North America who supported all recovery connections with alumni through the direction and support of the alumni services department. Volunteers were required to have 1 year of continuous sobriety, work a 12-step program of recovery, work with a sponsor, and help others through the 12 steps.

Regional alumni volunteers were directly involved with the alumni contact process and the facilitation of productive alumni chapter recovery support meetings. They also initiated and coordinated social events, recovery workshops, and other opportunities in the regional and local alumni recovery communities.

Similar to the regional alumni volunteers at the BFC, Caron operated a National Alumni Leadership Council that served under the leadership of the director of alumni relations and engaged the participation and support of alumni. Members represented various regions and served as contact persons from selected regional fellowship groups. The council chairperson served a 2-year term and was represented on the Caron board of directors. The council helped initiate, plan, and coordinate regional events and programs as well as serve on working committees. Table 14 outlines volunteer roles for alumni in treatment centers.

Table 14

Treatment Center Alumni Roles

Treatment Center	Alumni Roles
Betty Ford Center	<ul style="list-style-type: none"> • Initiated and supported local alumni meetings, social events, recovery workshops. • Maintained local alumni contact lists. • Coordinated with alumni contact processes. • Coordinated opportunities with the alumni community.
Caron	<ul style="list-style-type: none"> • National alumni leadership council served alumni under the direction of alumni relations. • Engaged the participation and support of alumni. • Members represented various regions, alumni chapters, and contact persons from selected regional fellowship groups. • Chairpersons served a 2-year term and were on Caron board of directors. • Volunteers helped initiate, plan, and coordinate regional events and programs. • Volunteers served on working committees. • Volunteers signed a confidentiality waiver.
Hazelden	<ul style="list-style-type: none"> • An alumni leadership committee was being formed in 2010 at each regional location to help advise Hazelden, plan activities and events, and create new service opportunities.

Each treatment program offered an alumni contact in the attempt to match patients with an alumnus to assist the client's transition to the home environment. The key goals for the alumnus were to be an active recovery supporter for the client during the transition time and help the client connect to the recovery community. The BFC staff, with volunteers' help, linked patients and alumni

through phone calls and ensured each discharging patient had a plan to connect with another alumnus within 24 to 48 hours after returning home. BFC staff also hosted a patient, alumni, and staff social hour each month to build more positive relationships with patients and help patients make calls to contacts during this social time. Volunteers throughout the country provided names of alumni who were willing to serve as positive recovery role models and alumni contacts.

Caron staff made calls to connect patients with alumni and sober members of the 12-step community. The staff maintained a record of good contacts and had other alumni make referrals of those who were willing to serve. Hazelden ensured every patient connected with alumni by phone prior to discharge. Hazelden alumni served as contacts by providing written consent to be contacted. There were 1,800 volunteers for this program. The alumni also called the alumni office to find a new contact when they relocated. Table 15 lists alumni contacts available to treatment center patients.

Alumni chapter meetings were support meetings facilitated by alumni and volunteers. These meetings served as a bridge for treatment center alumni to have a successful return home. They shared fellowship with other alumni who had shared common experiences and could also serve as a support system for the newcomer. BFC alumni facilitated approximately 35 to 40 alumni chapter meetings in the United States and Canada. These meetings followed the format of 12-step meetings and were held weekly or monthly. Caron held regional fellowship meetings led primarily by the director of alumni relations. They were 12-step formatted meetings with established group guidelines. Caron fellowship meetings were followed by business and event planning meetings. Hazelden had

15 local chapter meetings that were facilitated by alumni. The Chicago metro area, in close proximity to Hazelden in Minnesota, was a hub of local recovery activity and numerous chapter meetings were held throughout the area. Table 16 outlines alumni chapter groups available across the treatment centers.

Table 15

Treatment Center Alumni Contacts

Treatment Center	Alumni contacts
Betty Ford Center	<ul style="list-style-type: none"> • Patients were provided an alumnus contact to meet in their home area 24 to 48 hours after discharge. • Alumni service staff and volunteers linked the patient to the alumni. • Alumni service hosted a social hour each month for patients to become acquainted with staff and to discuss their progress toward making alumni contact connection. • Volunteers helped by providing names of active alumni to serve as contacts in the different regions.
Caron	<ul style="list-style-type: none"> • Unity in Recovery—Alumni Relations had staff make calls to connect patients with alumni and other 12-step program contacts.
Hazelden	<ul style="list-style-type: none"> • Hazelden alumni served as contacts by providing written consent to be contacted. There were 1,800 volunteers for this program. First, a staff member contacted the alumni to verify their willingness and to verify their continuous sobriety and participation in 12-step recovery. Then, the patient sat with Hazelden counselors or case managers as part of the aftercare plan and connected with the alumni via phone. Alumni also called the alumni office when they relocated to find a new alumni contact.

Table 16

Treatment Center Alumni Chapter Groups

Treatment Center	Alumni Chapter Groups
Betty Ford Center	<ul style="list-style-type: none"> • 40 alumni recovery meetings (chapter meetings) were held across North America, using a 12-step uniform recovery format. Meetings were held weekly, biweekly, or monthly.
Caron	<ul style="list-style-type: none"> • Regional alumni fellowship meetings were led by director of the alumni department. Twelve-step meetings and group guidelines were established. These meetings conjoined event planning meetings for community alumni activity.
Hazelden	<ul style="list-style-type: none"> • 15 alumni chapters were run by alumni in various cities. • There was strong support in several regions, including weekly recovery meetings at St. Paul in Chicago and monthly meetings in Oregon, New York, and Florida.

Alumni services supported new alumni by making phone contact with each alumnus as an additional recovery support service. The Betty Ford Center made calls to alumni four times within the first 100 days after discharge, and then once again on the patient's anticipated 1-year sober anniversary. These calls served to extend a helping hand and a heartfelt voice to alumni. A letter and medallion were sent to each alumnus after the fourth call at 100 days. With written permission, alumni volunteers called the new alumni at 30- and 60-day intervals to build a relationship and offer further recovery support. Similarly, Caron Recovery Care called the new alumni the first week and then monthly thereafter. Alumni graduates called newly discharged alumni to invite them to local meetings for extended recovery support. Hazelden alumni staff made calls to alumni for up to 18 months after discharge. Table 17 summarizes the ways alumni services follow up with alumni of Treatment Centers.

Table 17

Treatment Center Alumni Services Follow up with Alumni

Treatment Center	Alumni Services Follow Up with Alumni
Betty Ford Center	<ul style="list-style-type: none"> • Staff called alumni at 1, 5, 9, and 13 weeks as well as 1 year after discharge to provide support and guidance. • A letter and medallion were sent by alumni service staff after the fourth call. • Volunteers called alumni 30 to 60 days post-discharge to offer local recovery support.
Caron	<ul style="list-style-type: none"> • Recovery care services department placed calls to new alumni the first week and then monthly thereafter. The department provided telephone support and invited alumni to chapter support meetings and recovery events.
Hazelden	<ul style="list-style-type: none"> • Alumni had access to the MORE @ program and staff made follow-up calls to alumni for up to 18 months after their discharge.

Other Relevant Recovery Services

Relevant recovery support services were discovered in the research interviews. These varied services were relevant when considering developing a new model and integrating the best practices of CBOs and treatment center alumni efforts. These services included the medicated assisted recovery system, social and leisure activities, technology and phone support, 12-step support meetings, and anniversary weekends.

The CBOs either already offered or were in the process of developing services for recovering alcoholics and addicts who were required to take medication to help them integrate into the 12-step community. These programs were called medicated assisted recovery system groups. It was important for people with dual diagnoses to understand the necessity of taking their prescribed medication in combination with alcohol or other drug recovery. Peers who facilitated these sessions were required to have extensive experience in recovery.

Social and leisure activities were supported by all CBOs and treatment program alumni efforts. Understanding how to use newly found leisure time was critical for recovering persons. A wide range of sober leisure and social activities included attending Broadway shows, ball games, sobriety dances, barbecue and potlucks, themed holiday celebrations, game nights, art workshops and art shows, poetry readings, book clubs, bike riding, and much more.

Technology and telephone support was offered by all seven organizations. Each CBO had a Web site that listed its various programs and services. CCAR and PROACT both had a 24/7 telephone line for information, recovery referral,

and support. CCAR had an extensive telephone outreach that called clients weekly to check in, help people maintain recovery, and intervene early in the event of a relapse. CCAR also had developed a Web-based program that was a resource for identifying recovery homes in Connecticut. At the time of this study, CCAR was expanding this service nationwide. Additionally, as described earlier, alumni from all centers received follow-up calls for durations of 3 to 18 months.

Access to 12-step support meetings was provided and encouraged by all seven entities. VRN hosted meetings in its recovery centers that included AA, Narcotics Anonymous, Overeaters Anonymous, Sex Addicts Anonymous, Al-Anon, Adult Child Of Alcoholics, Gamblers Anonymous, Debtors Anonymous, Dual Recovery Anonymous, and Double Trouble Anonymous.

Anniversary weekends were held annually by all three treatment programs. The BFC hosted a weekend of recovery meetings; workshops; golf, tennis, and hiking events; and a banquet with entertainment and fellowship for 700 to 1,200 alumni. Caron hosted a weekend of pure fun that included games, balloon rides, drumming, and more. Caron also recognized alumni of the year, hosted a banquet lunch, and facilitated fellowship among the alumni. Hazelden alumni attend yearly reunions on the main campus organized by alumni. They stayed at the Hazelden renewal center. Other events were hosted at the satellite facilities.

Summary

The results of this research revealed that there were important similarities and differences in the ways that CBOs and treatment centers trained, utilized, and supported volunteers within their organizations. CBOs utilized volunteers

more broadly and they were more likely to be on the frontlines of recovery than in treatment centers which relied more heavily on professional staff. Treatment centers also dedicated fewer direct resources to volunteers and peer support since they were generally located outside the client's home community. In contrast, CBOs focused on integrating recovery into the home, family, and community environment. In spite of the differential commitments and utilization of volunteers by these organizations, the volunteers themselves reported similar motivations regardless of their training, role within the organization, or the external rewards of volunteering. The research also revealed a wide range of recovery programs and services delivered by volunteers, which may stimulate further consideration of these practices, by both CBOs and treatment programs.

Chapter 5

Summary and Conclusions

The purpose of this research was to determine what treatment providers at alcohol and drug treatment facilities could learn from CBOs about volunteerism as a way to support long-term recovery in a cost-effective manner. Based on this study, it was confirmed that CBOs rely heavily upon volunteer peer support to deliver their recovery services to people seeking recovery. Volunteers receive significant training in a multitude of recovery support programs. In contrast, treatment programs rely mostly on professionals to deliver treatment curricula during a shorter time period, with minimal resources expended to develop volunteers in post treatment.

The research indicated that CBO volunteers were involved with the clients in all stages of the recovery process. For instance, peers supported new clients upon entry into the recovery process by greeting them; listening to them; understanding their needs; and sharing their own experience, strength, and hope of their own recovery. In most agencies, they supported newcomers by helping them become familiar with and ease the entry into the 12-step process. Secondly, volunteers participated in training by supporting newcomers through recovery coaching, mentoring, and assisting in the development and follow up of personalized recovery plans. Thirdly, volunteer peers were trained in specialized programs such as post-traumatic stress syndrome groups based on Seeking Safety, a 25-week small group process characterized by dialoging, witnessing conversation, creating new possibilities, and holding space for the process. Peers also were trained in and co-facilitated a Nurturing Parents program, which

taught age appropriate parenting skills. The Rocking Horse Circle provided interventions for mothers aged 18 to 35 years.

In contrast, treatment programs relied on volunteers sharing their own hope and success from their personal recovery experiences. BFC was the one exception, as it supported volunteer training and certification through the Grief Recovery Institute in Sherman Oaks, California. In addition to sharing their stories of personal recovery, BFC volunteers were able to support peers and others recovering from grief and loss events.

Characterizations of volunteers from all seven organizations included each volunteer becoming a personal example of recovery. The volunteers whose recovery programs resulted in behavioral change toward more empathy, compassion, openness, confidence, and hope (Woody et al., 1999) had better recovery outcomes.

CBO volunteers were extensively integrated into their communities by helping new alumni with basic life skills such as finding employment, managing money, identifying social services, utilizing leisure time, improving personal health, and taking advantage of other pertinent resources within the community. Treatment program clients may have different needs than CBO clients. However, more thought can be given to how treatment center clients might be better integrated into the home environment based on their specific needs.

The typical structures of all the volunteer programs were horizontal, and based on the practice of service. These volunteer groups were not typically decision-making entities for the purpose of governance. For the most part, they

were modeled after AA's 12-Step peer support program. The interest of serving others was the common bond within these volunteer communities.

The CBOs provided family support as evidenced by focused programs on family recovery, women specific recovery programs, parenting skills, and developing healthy relationship with peer support, whereas these programs were delivered by professionals in treatment programs. Alumni efforts focused on including family members in the recovery support meetings, workshops, and leisure programs offered to the general alumni population.

Volunteers for CBOs and treatment programs received recognition in various ways. CBOs participated in dinners and celebration events and, in some cases, were awarded special recognition through certificates, additional training, and professional certifications. Treatment programs honored their volunteers in different ways, including special recognition at dinners and access to recovery programs. Most importantly, the research participants reported that the key motivation for all volunteers active in service was that it enhanced their own personal recovery.

Use of recovery support meetings was encouraged by both treatment centers and CBOs. Treatment programs offered access to 12-step meetings while in treatment and encouraged continued meeting attendance upon discharge. The treatment program volunteers served as contacts upon discharge to connect alumni to the 12-step communities in the home environments. The alumni recovery groups were modeled after the 12-step program; however, due to AA's tradition of non-affiliation, they were similar to but not conducted as active AA meetings. Most CBOs offered a variety of actual 12-step meetings in their

facility, or had volunteers take the client to local 12-step meetings within their own communities.

Impact of Study

Contemporary Western society considers the prominence of alcohol and drug addiction a chronic disease and a public health concern. Addiction takes a tremendous toll on individuals, families, medical organizations, and governments. In and of itself, the negative financial impact on society warrants the continuation of current research programs and treatment methods on the topic. The disease is pervasive and relapse is a condition of the problem. Increased efforts must aim at recovery support solutions to reduce relapse episodes and increase positive results, thereby, enabling the alcoholic and addict to return to normalcy and prosperity.

Volunteerism and peer support of recovery services and skills were promising strategies for extending the benefits of alcohol and drug treatment in a cost-efficient way. Due to financial constraints, CBOs invested in and relied heavily on the efforts of volunteers for program service delivery. CBO efforts met with great success, as the CBO model was long-term and focused on integrating the recovering person into his or her home environment. Treatment centers relied more on professionals and less on volunteerism for service delivery. Treatment centers represented an acute-care medical model and expended fewer resources on volunteer training and retention.

Given these qualitative differences in volunteer utilization between CBOs and treatment centers, this thesis asked what treatment providers can learn from CBOs about utilizing volunteerism as a way to extend the benefits of long-term

recovery in a cost-effective way. It took as a central premise the understanding that volunteerism may be a useful strategy for extending care beyond a treatment setting. Interviews with four CBOs and three treatment centers revealed important differences and similarities between the organizations and provided data that were used to suggest best practices for extending the benefits of treatment recovery. One of the most important findings of this research was that volunteers themselves benefited greatly from their involvement in treatment activities, regardless of the training, duration, scope, or recognition associated with volunteer service.

Despite volunteers' overwhelming personal experience in the recovery world and the benefits they stand to gain from helping others, there was scant scientific research on treatment center alumni volunteerism at the time of this study. Work by Zemore and Pagano (2009) was a notable contribution in the AA context and suggested that future research on volunteer motivation could play a critical role in extending the benefits of alcohol and drug treatment. Therefore, the research described here can inform future work on the benefits of sobriety that peers receive from helping others and also provide an assessment of the elements for successful peer support.

Limitations of Study

Three limitations affected this study:

1. This research sought best practices that could be shared between two types of organizations, CBOs and treatment centers; therefore, the research only examined the noted successes overall.

2. The study author's professional role within the recovery community shaped the interview questions and choice of organizations to compare and contrast, as well as access to professional staff at all seven organizations. While this study cannot be replicated due to its reliance on the study author's personal network and professional reputation, the lessons herein are valuable for organizations seeking a better understanding of how to utilize volunteers to extend the benefits of recovery from alcohol and other drugs.

3. The sample size was small and focused on only two specific types of organizations. The three treatment centers were acute care facilities of significant size with a client base that was geographically dispersed nationally and, to a lesser extent, internationally. The research does not represent smaller treatment programs with clients in local and regional settings. The CBOs were located in the Northeastern United States and were selected due to their successful programming and peer support efforts. There are a wide range of programs across the United States, which offer a wide range of services. Further consideration may be given for future collaboration and research for all CBOs as well as treatment programs, to share best practices.

Recommendations and Considerations

Based on the research of this thesis, the following recommendations are notable considerations, but by no means represent an exhaustive list of possibilities. Most importantly, this thesis may draw attention to the need to bridge the critical gap between treatment programs and the recovery community.

1. Balance proximity with distance. CBOs are successful, in part, due to the proximity of those they serve in close proximity to their services. Local

treatment programs also benefit when their alumni are in close proximity. Some treatment centers serve alumni who are widely dispersed. Treatment centers may develop groups of volunteers in high-density communities. Provide these alumni volunteers with developmental opportunities to clearly clarify their roles and strategic goals and to build a cohesive group spirit based on service. Working as a recovery group reaps greater benefits than working individually. Encourage the treatment center volunteers to explore utilization of community resources in their respective regions. While the variety and quality of these resources may vary from city to city, there may be hidden resources that provide helpful integration for many of the new alumni.

2. Establish a climate of peer support service in the treatment venue. Both CBOs and treatment centers can benefit from more extensive use of volunteers, beginning with the admissions process. Specific recommendations include providing ample opportunities for volunteers to share their experience, strength, and hope with those in treatment, starting with greeting them in the admissions process. Additionally, it is important to provide opportunities for alumni to speak on various recovery topics in lecture-style formats, including life in recovery, use of leisure time, sobriety and employment, and parenting. Also, it would be helpful to have volunteers deliver 12-step meetings to patients while in treatment, have volunteers introduce AA or other recovery pathways with programs like Making Alcoholics Anonymous Easier (Kaskutas & Oberste, 2002), and continue to explore more opportunities for peer support of patients in the treatment process.

3. Bridge the transition from treatment to the home environment. Alumni programs' primary purpose has been to serve as a low-cost, transitory

organization using a small number of regional volunteers to get the new alumni from the treatment setting into the local recovery community. Specific recommendations are to connect patients with external peers and contacts prior to discharge by telephone, email, and, when possible, face-to-face. Additional measures are to identify opportunities for patients to experience service to others prior to discharge and encourage patients to share their recovery plan with their alumni contact, so the alumni contact can better know and support the needs of the newly discharged alumni. Where alumni contacts are not available, it is important to connect the patient with AA meetings or Bridge the Gap, an AA program that assists people in transitioning from treatment center to the AA community.

4. Provide volunteers with additional training and recovery program benefits. CBOs provide extensive training to their volunteers. Treatment centers may focus more resources on training volunteers to build a more assertive and deliberate peer support mechanism for transferring recovery skills into the post-treatment environment. Specific recommendations include but are not limited to grief recovery programs; 12-step workshops; recovery coaching; working with personalized recovery programs; family support emphasis; ethics, HIPPA compliance, and values; and motivational interviewing and communications. Additionally, it would be helpful to identify alumni and community members who participate in other 12-step meetings that focus on issues such as dual diagnosis, sex and love addiction, gambling, eating disorders, and couples' recovery. Other supportive mechanisms include leadership training for volunteers who show strong support within their respective regions, work-life support, and sober leisure

activities. Along with recovery skill training in service to others, volunteers may be provided programs for their personal recovery benefit. Recovery programs help volunteers maintain their own strength of recovery, in turn, enabling them to pass on a higher degree of experience, strength and hope to their fellow recovering persons.

5. Create a community of sober fun and leisure activity. Treatment volunteers in their respective communities may consider planning a variety of self-directed leisure events, supporting the recovery community in building pro-social behavior as well as constructive use of newly found free time. A sampling of these activities may include book clubs, creative writing, artist days and poetry readings, photography, lawn games, picnics, sports activities, hikes, bicycle rides, yoga sessions, participation in recovery walks, and prayer and meditation groups.

6. Collaborate with and learn from CBOs. In this research, programs offered by CBOs were varied, extensive, and comprehensive. While it is uncertain to know the extent of services provided within communities outside the research sample, it is worthy to consider the CBOs as a resource when alumni return to their home communities. Further opportunities for collaboration may be explored. More attention can be given to sharing best practices and resources within the CBO community. While many of the services delivered by CBOs are shared programs (many of which are available to the public and were developed through government funding) and creative in their own right, programs developed at the local level of high value and interest. One unique example of this type of program is the Tree of Hope project in Bucks County, Pennsylvania. Treatment

centers may emulate this project by honoring alumni in recovery, those who support their recovery, those who have died of the addiction, and those who have passed on as sober members on holidays or at their annual gatherings. Patients and alumni could be invited to be involved in honoring in this celebratory event. A second example is the Legacy of Hope-Recovering Elders Project from CCAR. This project honors ultra long-term recovery using a 30-minute documentary of interviews with sober people and their friends and family along with a pictorial view of the recovering people's lives. This model could be adapted for delivery to patients and in Web media.

These recommendations are threads of recovery support that begin to weave a wide web of care for the person just beginning the path of recovery and benefit those who continue on the recovery road. Understanding that the primary tenant of recovery is that people remain sober when they are in service to their fellow recovering alcoholics and addicts, these recommendations serve as additional opportunities for volunteers to benefit their recovery while helping others. In addition to the primary support of 12-step, treatment programs, CBOs provide additional opportunities to increase the possibility of long-term recovery.

Summary

Through this research, treatment centers can learn about ample opportunities to enhance their effectiveness through use of volunteers and can learn through what CBOs are doing now. Partnering between treatment centers and CBOs also may yield effective long-term treatment for the debilitating disease of addiction. This pipeline of recovery support, although still porous, may yield better recovery outcomes by keeping more addiction out of the sobriety

pipeline and more recovery inside the pipeline for the newly recovering persons. Constant vigilance and assertive attention to this continuum of care is critical to offset the ravages of alcoholism and drug addiction. The devoted efforts of volunteers and those who provide recovery support provide a more generative and dynamic recovery community for all who seek freedom from the bondage of this disease.

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Appendix
Interview Protocol

Interview Protocol

- 1) What are your organization's most successful programs in support of your clients' continued sobriety? Please describe the essential components of these programs.
- 2) How do you evaluate the success of these programs?
- 3) Which of these programs are primarily supported by volunteers?
- 4) What training do volunteers participate in to help fulfill their mission?
- 5) How are the volunteers managed and directed in the efforts?
- 6) What do you think are the volunteer's primary motivators for working with alcoholics and addicts