

A HISTORICAL ANALYSIS OF THE INITIAL FIVE YEARS OF RECOVERY
CONSULTANTS OF ATLANTA, INC.: A FAITH-BASED, PEER-LED ADDICTION
RECOVERY AND HIV PREVENTION PROGRAM

by

DAVID LEE WHITERS

(Under the Direction of Cheryl D. Dozier)

ABSTRACT

In September 2001, Recovery Consultants of Atlanta, Inc. (RCA, Inc.), a faith-based, peer-led Recovery Community Organization (RCO), founded by a member of Atlanta's 12-step addiction recovery community, received a 5 year, 1 million dollar Recovery Community Services Program (RCSP) award from the Federal Center for Substance Abuse Treatment (CSAT), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA), in the US Department of Health and Human Services (HHS). This award charged the founding member with the responsibility of developing and implementing a variety of Peer-Based Recovery Support Services (P-BRSS): interventions and programs designed to reduce relapse and sustain long term recovery among individuals overcoming drugs and/or alcohol addiction. Though there is little empirical support for P-BRSS, massive societal costs attributed to illicit drug use combined with incessant closing of both public and private drug treatment programs have prompted the need for innovative and cost efficient methods for curtailing America's addiction problem. This dissertation examined the successes, challenges and experiences of RCA, Inc.'s peer-led recovery program, with a special emphasis on how services

were developed, by whom, and for what audience. Outcome measures such as reduction in substance use, criminal activity, and substance use related ailments, i.e. HIV and Hepatitis C infections, among service recipients, were the parameters by which the program was evaluated.

KEY WORDS: Peer-led Recovery Support Services, Recovery Community Organization, Addiction, Recovery, Faith-based, Afrocentrism, Community Development

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DEDICATIONS

I would like to begin by dedicating this work to the memories of my mother, Ms. Ollie Dell (Grayson) Wheters, who passed away on January 31, 2010, my father, Mr. Samuel Joshua Wheters, who passed away in 1991, and my oldest sister Sadie (Wheters) Davis, who passed away in June, 1986. They were each wonderful examples of the spiritual principles commitment, love, and determination. It was their spirits combined with those of the ancestors that kept me motivated and determined. Without their transcending support, I am not sure that I would have had the energy or fortitude to complete this taxing project. I thank God for allowing me to be a part of their lives. I miss each of you dearly and I love you so very much.

Next I would like to dedicate this work to my remaining nine siblings, beginning with my sisters Geraldine (Wheters) Zimmerman, Frenchy (Wheters) Jones, Francis Dorethea Wheters, and Pamela Wheters. These ladies are my heart and soul. Their love for me is total and without conditions. I cherish their friendships and I thank God for each of them.

Next, I want to thank my big brothers Esjaye, Stanley, Randolph, Rodney and my little brother Marcus. What a blessing it is to grow up with 5 brothers and 5 sisters. I have been spoiled since the time I was in my mother's womb. I know my brothers love me and I know they are so very proud of my recent accomplishments. Each day I thank God for blessing me with wonderful siblings. Thank you all for allowing me to be a part of your lives.

I would also like to dedicate this work to the original dream team at Recovery Consultants of Atlanta, Inc., Cassandra Y. Collins (boss lady), Michael Jones, Stephanie Nelson, Joe Cobb, Somjit Ball, Will Parrish, Robby Travis, and Anita Jones. Thank you all for your

support and encouragement. This major accomplishment is as much your reward as it is mine. I feel as though we completed this in the spirit of “team work” that for the past eight years has been the foundation of RCA, Inc. Thanks for being the great team members and friends that you are. I love each of you in a very special way.

I would be remised if I did not take a moment to thank all of the wonderful volunteer staff and clients at RCA, Inc. For the past 10 years I have been blessed to work with and serve some of God’s greatest people. RCA, Inc.’s core group of volunteers, mostly men and women who self-identify as persons in long-term recovery (12-step and/or faith-based), have proven that they are the reason why RCA, Inc. is one of America’s leading Recovery Community Organizations. In addition, the clients have been equally important. There have been several hundred homeless substance users who have come to RCA, Inc. seeking services while feeling completely hopeless, only to see them make major-positive changes in their lives and behaviors. What a blessing it has been to witness those changes. I want to thank God for allowing me to work with and serve such a wonderful group of people.

And finally, I would like to send out a very special dedication to my hero, mentor, and biggest advocate, H. Westley Clark, MD, Director of the Federal Center for Substance Abuse Treatment. Though I have been blessed to have several wonderful people in my life while I pursued my PhD, none were as motivating as Dr. Clark. He told me that I was brilliant so many times that I began to believe it myself. This accomplishment (completing and defending my dissertation) is as much his as it is mine. Thanks Doc for being there for me, especially during the times when I was not sure if I would make it. Love you from the bottom of my heart.

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Before Dr. Dozier became the chair of my committee she was one of my biggest advocates. She believed in me on days when I was not sure if I believed in myself. Her never ending love for Christ, her family, her community, underserved populations, and for me have been consistent since the day she and I first met. I will always remember her as the force behind my completed dissertation.

To Dean Maurice Daniels, the second African American Dean at the University of Georgia and one of the busiest men I know, though he was never too busy for me. Dean Daniels has a special way of making me feel important and he could do this during the times when he had far more pressing issues to attend to than me. But you would have never known it. I have prayed that God would allow me just one uninterrupted hour with Dean Daniels so that I can pick his brain for all the wonderful knowledge he has. Like Dr. Clark, Dean Maurice Daniels, PhD is one of the brightest men I have ever met. I am trusting that God will one day answer my prayer and allow me one uninterrupted hour with the Dean.

Professor Ezemenari M. Obasi, PhD, a brilliant scholar with a kind heart. The creator is more than pleased with this brother. His commitment to assisting me through my academic sojourn while simultaneously managing his own many existing responsibilities speaks to the

robust nature of his heart. Thank you so much Professor Obasi for assisting me through this process.

Professor Denise Bacchus, PhD, a brilliant sister with a strong commitment to social work, social change, and social work students. Our friendship began as colleagues and segued into a professor/student relationship. She was the “right on time” committee member. She said, “David, you can and will complete your dissertation.” Thanks Dr. B. for being right on time.

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ACRONYMS AND DEFINITIONS

1. Addiction – also referred to as drug addiction: Refers to an individual's inability to remain drug and or alcohol free even when the individual realizes that to continue this behavior may lead to incarceration or death.
2. Afrocentric, Afrocentric Paradigm, Afrocentricity, Afrocentrism, African-centered (terms used interchangeably): Refers to a set of principles and practices based in African heritage that are used in this study to motivate African American clients into positive thinking, actions, and beliefs.
3. Alcoholics Anonymous (AA): A 12-step program designed to help men and women overcome addictions to alcohol.
4. Associate Director (AA): the second person in command at Recovery Consultants of Atlanta, Inc.
5. Centers for Disease Control (CDC): Federal agency that provides funding to community based organizations to fight infectious diseases.
6. Center for Substance Abuse Treatment (CSAT): Federal agency that funds Recovery Consultants of Atlanta, Inc.
7. Executive Director (ED): The first person in command at Recovery Consultants of Atlanta, Inc.
8. Macro Practice: A termed used in this study to define the role social workers can play in organizing the recovery community.

9. Narcotics Anonymous (NA): A 12-step program responsible for helping men and women overcoming addiction to drugs.
10. National Institute on Drug Abuse (NIDA): Federal agency responsible for funding institutions conducting research on drug abuse and drug treatment.
11. Peer-based Recovery Support Services (P-BRSS): A set of services and programs created by individuals who identify as persons in addiction recovery for individuals seeking recovery.
12. Peer: Refers to a person providing P-BRSS. (interchangeable with #8 below).
13. Recovery - also referred to as Addiction Recovery: Refers to an ongoing process taken by an individual who is attempting to overcome an addiction and remain alcohol and or drug free, one day at a time.
14. Recovery Coaches, Recovery Mentors, Recovery Support Specialists (are terms used interchangeably): Refers to a person in addiction recovery who has been trained to provide low cost or free services to individuals seeking recovery.
15. Recovery Community Organization (RCO): An agency that has as its primary purpose developing services that will help suffering substance users find recovery.
16. Recovery Consultants of Atlanta, Inc. (RCA, Inc.): The agency being examined in this study.
17. Recovery Oriented Systems of Care (ROSC): A system of agencies with shared ideas focusing on developing services designed to assist active substance users find recovery.
18. Relapse – a return to drug and or alcohol use after attempting to refrain through recovery.
19. Substance Abuse and Mental Health Services Administration (SAMHSA): The federal parent organization to CSAT.

20. Treatment or Addiction Treatment: Refers to a process that an individual who is trying to overcome a drug and/or alcohol addiction can go through to help them reach this goal.

Treatment can be in the form of residential (inpatient) or outpatient.

“We envision a society where people who are addicted to alcohol or other drugs, people in recovery from addiction, and people at-risk for addiction are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. We envision a society where addiction is recognized as a public health issue - a treatable disease for which individuals should seek and receive treatment; and where treatment is recognized as a specialized field of expertise” (CSAT National Treatment Plan, 2000).

PREFACE

I was born and raised in Pontiac, Michigan during the time when this urban-industrial city consisted of several middle class communities and a Black population that hovered round 50 percent. The majority of its residents worked in one of the many General Motors (GM) plants located throughout the city. Life appeared to be good for most residents because of the abundance of employment opportunities provided by GM.

During the late 1960's, around the time of the infamous 1968 Detroit race riot (just 25 miles north), Pontiac would begin to experience a heroin epidemic that would gradually ruin the lives of two of its most valued residents – Black men in their prime and Black women of child bearing age. By the mid 80s, the heroin epidemic that plagued this small industrial town would be augmented by the crack-cocaine epidemic, ensuring the ongoing destruction of much of Pontiac's booming Black middle class. This epidemic, combined with the incessant decline of the auto industry, would transform Pontiac from a once thriving community to a “ghost town” with one of America's highest unemployment rates and a devastated drug using culture.

My Parents

Both my parents migrated from the south to seek employment opportunities provided by the auto industry and its ancillary companies. My father, his father, and my father's 4 siblings, a

brother and 3 sisters (his mother died when he was 13), moved from a small town in Tennessee to Pontiac in 1936. He was 20 years old when “he migrated north.” He and his family lived in a government project located on the west side of Pontiac, constructed primarily to house individuals and families migrating there to work. Almost immediately, my father was hired in one of the GM assembly plants.

My mother moved to Pontiac when she was 19 years old to live with an older sister who had moved from their hometown of Jackson, Mississippi a few years earlier. She came for two primary reasons: the first was because her mother had recently passed and her father thought it would be better if she lived with her sister, and the second was to look for employment. She lived with her sister and brother-in-law in the same projects that my father, her future husband, lived. Shortly after moving to Pontiac she also went to work, but not for GM. She secured a job as a stock worker in a storage department at a local hospital.

My Family

The union between my father and mother resulted in 11 children. My family includes six boys and 5 girls, and I am number 10. I have one younger sibling, a brother. Several of my siblings would eventually go to work at GM. As a child I can remember being spoiled or treated extremely special by several of my older siblings. It appeared they always had money and gifts for me. It was fun being raised by parents who were both employed and siblings who also seemed to have money. Though my parents divorced when I was 5, they were both involved in my life, though my father’s involvement centered primarily on him giving me money when I asked him for it.

My Story

I often refer to my childhood as a typical, urban, African-American male experience. At a young age I was exposed to the “street life” that among other things included drugs, alcohol, and crime. I realized early in my life that I was attracted to the people in my community who wore flashy clothes and drove expensive cars. These were the individuals I aspired to emulate. While I am not proud of this childhood attraction, I will not pretend as if this was not my attitude because it was. Nor am I attempting to give the impression that this was the attitude of all African-American males growing up in my community because it was not. Several of my friends saw these people as nothing more than “community bloodsuckers,” worthy of neither praise nor respect. Because my family included both a sister and a brother, each with their master degree, who served as role models for me, it is difficult to explain why I had such an attraction. However, my obsession was with the “streets” and it would be this obsession that would ultimately lead to several years of pain and misery.

Shortly after entering Junior High school I began experimenting with marijuana. It was during this period that my attitude became so rebellious that I was given the ultimatum by the school administration to either begin taking Ritalin or suffer permanent suspension. The summer prior to my entering the ninth grade I took an aptitude test for enrollment in a private high school. I scored well on my test and was offered a partial scholarship. My mother was extremely excited and saw this as an opportunity for me to achieve a first class education and for her to get even with our local school system (she hated them for making me take Ritalin). Unfortunately for her I was not as excited, and could not comprehend the idea of leaving my friends to go to school with “a bunch of white kids.” In spite of my mother’s pleas, I objected vehemently until she asked no more. Soon after this decision, my addiction, a disease that I believe I was born

with, began to manifest. I began smoking marijuana daily, subsequently leading to poor grades. Little did I know that the decision I made not to go to the private school, combined with my daily marijuana use, would serve as the gateway to what would become 12 years of pure hell for me.

Addiction

I was in high school when I first began experimenting with heroin. It had taken me several years to become addicted to marijuana, but only a short time to become addicted to heroin. My addiction had become so bad I dropped out of high school in the 12th grade. I began traveling the country, “trying to find myself.” One of the first cities I moved to was Atlanta. While in Atlanta, I earned a GED, and even found a job. Though it appeared my life was getting better my disease was waiting patiently for the right moment to strike. From here I moved to San Francisco, the city I credit with bringing out the socialist in me. Growing up in my hometown of Pontiac all of my friends were Black. But in San Francisco, I made friends with people from many different nationalities. Living in the Bay area was truly a wonderful experience, but it was not long before my addiction took over and I was forced to move again.

Several years passed and I traveled between several cities. Finally, in 1984, I moved back to Atlanta. I prayed that I would settle down this time and get myself together. However, the cunning disease of addiction had its own agenda. After living in Atlanta for only a short time, I was back to using heroin on a daily basis. While in Atlanta, I shared an apartment with my nephew and one of his friends. They were also heroin addicts and the three of us “got high” together. One day, after becoming “sick and tired of being sick and tired,” I dropped to my knees and prayed that old-famous prayer, “please God help me.” Shortly thereafter, on July 18, 1984, I went to my first 12-step support group for addicts. Since that day, I have been completely abstinent from all drugs, including alcohol.

In the subsequent years, I became very active in Narcotics Anonymous, a 12-step support group for addicts, and quickly gained a reputation for being committed to helping others overcome their addiction to drugs. It was this commitment that led to my first job in the “helping profession,” as a substance use counselor. I was employed in a program that was designed specifically to treat African Americans. In the early 1990’s, I developed an interest in working with substance users who were also HIV positive. I was one of Georgia’s first substance use counselors to facilitate a support group primarily for HIV positive substance users.

I was only 26 years old when I began my recovery from drug use. It was because of this that I was often recruited as a motivational speaker for young people, showcased at community events, and solicited for input into the development of new programs. However, my educational status included only a GED and this hindered me from advancing my status as a substance use counselor. My employers would constantly tell me that “I did not have the credentials.” Yet, in many cases, I knew as much and in some cases more about substance use counseling than several of my colleagues with advanced degrees. This resentment prevented me from pursuing my college degree. My attitude was to prove to them that I could make it even without a degree. At that time I did not seriously consider going to college. I believed that my life experiences and my involvement in 12-step recovery were credentials more valuable than a formal education. However, the time finally came when I realized that unless I improved my educational status I would not be able to continue my career as a substance use treatment professional.

In May of 1993, I decided to relocate to Pontiac and pursue my college degree. With this decision came several barriers and challenges. First, at the age of 35, I felt as though I might be too old to begin a college career. I figured I would be in my 40s by the time I graduated. Secondly, I had not been in school for over 18 years and I literally did not know where to begin.

Lastly, I had no earthly idea of how I would attend school and financially support myself.

However, I knew without a doubt that I had to earn my degree and I had to begin the process immediately, or risk being stuck in a dead end job for the rest of my life.

College life was extremely difficult. I quickly learned that I had very poor study habits (actually, I had no study habits at all) and I didn't read very well. I could read books and literature from my 12 step support groups, but no other literature seemed to hold my interest. I was forced to become active in study groups and this proved to be an additional challenge. Most of my close friends were all members of NA. Over the years we had developed our own language and shared a common philosophy on life. In other words, we all had a "program." My cohorts in my study groups had no "program." This made it difficult for me to interact with them. Studying in the library was also challenging. The silence would literally drive me crazy. Instead of studying, I would often find myself sitting, staring into space, and daydreaming. At the recommendation of one of my professors, I was tested and diagnosed with an adult version of Attention Deficit Hyperactivity Disorder (ADHD). This ailment made it difficult for me to follow directions, remember information, concentrate, organize tasks, or complete work within a specific time limit. In spite of this, I was able to complete two associate degrees, one in general studies and the other in mental health/social work. Shortly thereafter, I was accepted into the Non-Bachelorette MSW program at the University of Michigan.

The University of Michigan offers a unique program that allows up to 10 students, who do not have undergraduate degrees, enrollment into their MSW program, annually. My life and human service experiences made it possible for me to advance from the Associates degree program directly into the Masters Degree program. Not only did Michigan claim that its social work program was number one during the time that I was there, but they also boasted that they

were the only school in the country that offered the Non-Bachelorette MSW program. This program is limited to Michigan residents and only 4 students were accepted the year I was admitted. Had I chosen to pursue my degree in Atlanta as opposed to Michigan, I would not have been eligible for this program. Securing recovery from my addiction and earning my MSW degree without first earning an undergraduate degree are just small examples of how God has truly blessed me.

Graduate school presented a new set of challenges. During my drug using days, I would experience these overwhelming feelings of uselessness, hopelessness, and inadequacy. Suddenly, these feelings resurfaced and I was beginning to wonder if I was “smart” enough to be a student at the University of Michigan. I began to wonder how many of my classmates and professors believed I was there because of affirmative action. I was experiencing these feelings even though I had graduated with honors in one of my associate degree programs. I also had issue with the relatively small number of African American students on campus at Michigan. I did not believe that the white students could truly identify with my experiences. I was not sure if these were feelings unique to individuals recovering from drug addiction but I did know that they were feelings that were causing me a great deal of pain. In spite of these challenges, on December 21, 1998, I earned my Masters Degree in Social Work from the University of Michigan. Today, I understand very well the meaning of the passage from my 12-step program, “*The wreckage of our past.*” If I had life to live over again I would have avoided my attraction to the “community bloodsuckers,” avoided drugs at all cost, accepted the high school scholarship, and went to college and earned my degree. Hindsight is 20/20 right? However, I don’t have life to live over again, but I am committed to doing all I can to help others avoid the painful experiences that I encountered. This is why I chose social work as a profession, created the nonprofit addiction

treatment and HIV prevention program Recovery Consultants of Atlanta, Inc., and accepted Christ as my Lord and personal savior.

I mentioned earlier that during my early days in Atlanta, I shared an apartment with my nephew and a friend. I would like to add that in June 1991, my nephew, who was also my best friend, died from complications due to AIDS. Shortly thereafter, our friend was sentenced to 25 years to life in prison for robbing several businesses. As for me, I am HIV negative and celebrating more than 25 years of recovery. I also mentioned earlier that I have 5 brothers and 5 sisters. Well I am happy to report that my oldest sister was 9 years sober in Alcoholics Anonymous when she passed from cervical cancer in 1985. I was almost 2 years in recovery at the time and she played an important role in my remaining drug and alcohol free during her last days. She told me “that I could not allow her dying to be an excuse for me to use drugs again”. Whenever I have a bad experience and using drugs seems like a viable solution for easing my pain, I just remember her dying words. I am also proud to report that 4 of my 5 brothers are all members of Narcotics Anonymous. Somehow, my oldest brother escaped the horrors of addiction. I have a brother who has 24 years clean, another with 16 years clean, another with 14 years clean, and my youngest brother has 12 years of continuous recovery. My mother is an extremely proud woman because she was able to see her sons recover from their addiction before she transitioned to heaven on January 31, 2010.

As a result of my personal recovery, I have been able to earn an MSW degree, help start Narcotics Anonymous in Durban, South Africa, create, develop and raise more than 10 million dollars for the faith-based non-profit organization Recovery Consultants of Atlanta, Inc., help thousands of homeless addicts find recovery from addiction, develop a state of the art HIV prevention project for homeless adult men and women substance users in Atlanta, GA, replicate

this model in Nairobi, Kenya, and pursue a PhD in social work at the University of Georgia. In spite of these achievements, what I am most proud of is my new found relationship with Jesus Christ: the one I choose to call “the real higher power”. I was able to establish this relationship through contacts with church members and Christians who were a part of the faith-based coalition established by Recovery Consultants of Atlanta, Inc. My relationship with Christ has led to a wonderful relationship with my pastor, church, and several church members. They all play a key role in my life and have helped me understand how important it is that I work daily to improve my relationship with Christ so that I have the strength to continue my work liberating homeless, African American drug users. Through my role as an African-centered, Christian social worker, my calling has been made perfectly clear. I am responsible for helping suffering addicts find recovery and reconnect or establish a relationship with God - because recovery without God is futile. Even the original members of Alcoholics Anonymous figured this out many, many years ago.

AUTHOR BIAS

It is important to begin this study with the disclosure that the author has several clearly defined and identified biases. Throughout this study, the author uses the phrase “founding member.” This phrase refers to the author who is the founding member of RCA, Inc. In addition, the author makes several comments that imply that Peer-based Recovery Support Services (P-BRSS) are the most effective intervention for serving homeless drug users in need of or seeking addiction recovery. Often times, these positions are made without empirical support. This is because for more than 9 years, the author of this study has worked as both executive director and peer counselor in a SAMHSA/CSAT funded Recovery Community Services Program. A belief among some within the RCSP movement (this author included) is that P-BRSS are the most effective intervention for sustaining long term recovery among recovering substance users.

Another bias that is important to point out in this study is one based on a belief implied by the author that African Americans in addiction recovery achieve the most out of addiction recovery when they receive African-centered P-BRSS and develop or maintain a strong belief in God. This bias is derived from the experiences of RCA, Inc., which identifies itself as a “faith-based organization,” and more specifically a “Christian organization”. It is also derived based on support by several African American scholars that African Americans by nature are strong believers in God.

CHAPTER I

Introduction

RCA, Inc. was founded in 1999 by a concerned and committed member from inner city-Atlanta's 12-step recovery community. This member, a high school dropout and former drug addict, was able to find recovery from his addiction, earn a graduate degree in social work, and pursue his dream to develop a non profit RCO that would help other suffering addicts find peace, joy, and happiness through recovery. White (2006) describes an RCO in the following manner:

Recovery Community Organization is a term used to convey the sense of shared identify and mutual support for those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both professionals working in the behavioral health fields as well as recovery supporters within the wider community. (p. 262)

During the period October 2001 to September 2002, RCA, Inc.'s founding member spearheaded an advocacy movement within Atlanta's 12-step addiction recovery community educating a select group of members and teaching them how to tell their story of recovery without violating the "anonymity" principle of their respective 12-step fellowship (e.g. Alcoholics Anonymous, Narcotics Anonymous). Anonymity is the foundation on which 12-step fellowships are based. This principle forbids members of 12-step fellowships from disclosing in public their membership or that of others. Advocacy with anonymity is a RCO principle that teaches individuals in recovery how to share their recovering story publicly without disclosing

their membership in a particular 12-step fellowship. The peer-based recovery movement views this as an important practice that helps educate society on the value and success of addiction recovery while simultaneously protecting the confidentiality of individuals involved in the movement.

A fundamental principle of this peer-based recovery movement was to develop a core group of speakers who would articulate to residents throughout Atlanta as well as to local, county, and state legislators the message that addiction is a disease and not a moral deficiency, and that recovery from addiction is possible and a reality for many. In the peer-based recovery movement this is commonly referred to as “advocacy with anonymity” or “stigma busting.”

Between October 2002 and September 2006, RCA would expand its focus and enter into a spiritual collaboration with a core group of inner-city Atlanta churches. Together they would develop a “faith-based coalition” and began implementing a plethora of social support services referred to as peer-based recovery support services (P-BRSS). These services were designed to help men and women seeking recovery from alcohol and/or drug addiction begin and sustain their recovery. This experience would serve as the foundation of a historical moment in Atlanta’s addiction recovery culture – one that would raise awareness, reduce stigma, encompass Christian pathways to recovery, and bring to rest the ignorance surrounding addiction and recovery.

Drug Use in America: A Real Time Perspective

Substance dependence and substance abuse, also referred to as addiction, are chronic disorders (American Psychological Association [APA], 2001) that directly affect millions of Americans. In 2008, there were more than 22 million Americans, 12 years old and older, impacted by these disorders (National Survey on Drug Use and Health [NSDUH], 2009). Of this total, 3.1 million were classified with dependence on or abuse of both alcohol and illicit drugs,

3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.2 million were dependent on or abused alcohol but not illicit drugs (NSDUH, 2009).

As it relates to illicit drug use, the groups most impacted by this disorder are individuals who identify as having 2 or more races, representing 14.7 percent, followed by African Americans, representing 10.1 percent (NSDUH, 2009). Current illicit drug use means use of an illicit substance during the month prior to the NSDUH survey. As it relates to alcohol abuse, African Americans (41.9 percent) trail whites (56.2 percent), persons reporting two or more races (47.5 percent), American Indians or Alaska natives (43.3 percent), and Hispanics (43.2 percent) as the group most impacted by this ailment (NSDUH, 2009).

Results from the NSDUH survey show no percentage change in either illicit drug or alcohol use among Americans between 2002 and 2008. However, two end results of these disorders, HIV infection and viral hepatitis, continue to disproportionately affect African Americans (CDC, 2009).

Similar to other chronic disorders such as diabetes and hypertension, addiction requires specialized treatment (Doweiko, 2002). However, due to rising health care costs and incessant closing of both private and public funded drug programs, treatment has become an option accessible primarily by the privileged (Johnson & Roman, 2003). Of the estimated 22 million Americans impacted by addiction, 2.3 million (9.9 percent) received treatment in 2008 (NSDUH, 2009). Thus, 18 million people who needed treatment for an illicit drug or alcohol use problem did not receive it in the year preceding this report.

Minorities and those lowest in socio-economic status are least likely to receive treatment for a substance use disorder and most likely to relapse after receiving it (Scott, Foss & Dennis, 2004; Jacobson, Robinson & Bluthenthal, 2001). A cause for disappointment resulting from this

reality is the fact that substance users who attend support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) post treatment can expect a 65 percent chance of remaining drug free for one year (Miller, 2001). A majority of individuals who find their way to 12-step support groups do so as a result of first being in treatment (Cloud & Granfield, 2001).

Statement of the Problem

Drug and alcohol addiction is a worldwide health issue that extends as far back as the 18th century (Leminski, 2001). It is an ailment that is among the most widespread bio-behavioral condition in the United States (Albanese & Shaffer, 2003). Albanese & Shaffer also report that the National Comorbidity Survey estimates that among the US population ages 18 to 54, the one year prevalence of alcohol and drug use disorders is approximately 10 and 4 percent respectively. Among people with a psychiatric disorder, prevalence rates are even higher. Albanese & Shaffer (2003) report that between 11 and 18 percent of individuals diagnosed with an addictive disorder also sought treatment from the specialty mental health services sector. This is not surprising since it is estimated that in 2008 more than 2.5 million adults, 18 years and older, with a serious mental illness were dependent on or abused illicit drugs and/or alcohol; suffering a co-occurring addictive and mental disorder (NSDUH, 2009).

While addiction among Americans continues to remain constant, access to appropriate treatment options continue to decline (McLellan, Carise, & Kleber, 2003; Johnson & Roman, 2003). Over the past two decades, due in part to managed care and rising healthcare cost, America has witnessed a 30 to 40 percent reduction in both public and private treatment programs (McLellan et al., 2003; Roman & Johnson, 2003). A fallout from this incessant decline has been an increase in substance use related illnesses such as HIV and viral hepatitis (Bell, 2002; Johnson, 2000) and an increase in substance related psychological impairments including stress,

trauma and memory deficiencies (Farley, Golding, Young, Mulligna, & Minkoff, 2004). In addition, the economic costs attributed to drug and alcohol abuse on the United States has grown to approximately \$1 trillion dollars annually (Califano 2007). Califano also states that substance abuse is a major reason behind most of America's social ills. He also highlights the costs of drug abuse in the nation's criminal justice, health care, and social service systems, and reports that this one epidemic is responsible for the death of more Americans than all of America's wars, natural catastrophes, and traffic accidents combined.

A disturbing concern regarding addiction centers on the way the general public perceives and forms opinions regarding this ailment. Stigma, or the negative views and opinions held by many regarding addiction is extremely troubling. A national survey among 801 American adults conducted by Faces and Voices of Recovery (2004), America's largest addiction advocacy organizations points out the following fact:

- (1) A majority of Americans have been impacted by addiction to alcohol or other drugs with over one-third knowing someone who is in recovery from addiction to alcohol or other drugs.
- (2) This same percentage report that discrimination against people in recovery is a problem in their community and sizable minority admit they would be less likely to hire an otherwise qualified job applicant if they learned that person were in recovery (retrieved October 15, 2009 www.facesandvoicesofrecovery.org).

Drug Use in Atlanta and its Related Ailments

According to Marsteller (2004), African Americans living in Atlanta, Georgia have the greatest need for drug treatment when compared to any other group of Georgia residents. This assessment continues by stating that of the estimated 730,000 adults in Georgia with a need for substance use treatment, 222,000 (30.4 percent) reside in Region III (metro-Atlanta), and of this

total only 21,373 (< 1 percent) received treatment in 2001; the year prior to when this report was published. In addition, this assessment continues by reporting that of the 222,000 Region III residents in need of treatment, 57,172 (25.79 percent) will require public funding if and when they decide to seek care.

Behavioral Health Link (BHL) is the Georgia agency responsible for managing the Georgia Crisis and Access Line, a toll-free-call-in-service for state residents seeking addictive and/or mental disorder treatment services. In fiscal year 2008, Region III residents placed 50.81 percent of the 183,371 (93,170) calls for help to BHL. Of this total, 55.1 percent (51,243) were African American, 39.4 percent (36,709) were White American, 5.1 percent (4,756) were Latino and Asian American, 10.1 percent (9,410) were homeless, 1 percent (931) veterans, 20.22 percent (18,839) sought help for substance use treatment only, 16.76 percent (15,615) were seeking help for a co-occurring mental and addictive disorder, and 69.35 percent (64,613) had no insurance or financial means to pay for services (retrieved October 16, 2009, from www.behavioralhealthlink.com).

Substance Use and Homelessness and their Related Ailments

The correlation between substance use and homelessness and their related ailments such as HIV, viral hepatitis, and criminality within the African American community, has been well documented throughout the peer-reviewed literature (Centers for Disease Control & Prevention [CDC], 2009; National Institute on Drug Abuse [NIDA], 2002). The metro-Atlanta Tri-Jurisdictional Collaborative Homeless Survey (2003), covering the City of Atlanta and DeKalb and Fulton Counties, prepared by the Homeless Census Advisory Council, under the section “demographics,” reports that 16,625 persons were homeless in Atlanta at some time during 2002.

This document continues by reporting that 47 percent of the survey respondents were homeless due to drug and alcohol use and 87 percent were African American.

The peer-reviewed literature has clearly identified a correlation between substance use and HIV-infection, particularly among America's homeless drug using community (CDC, 2009; NIDA, 2002). In a 5 year summation of RCA, Inc.'s federally funded HIV prevention project, it was reported that of the 7,798 homeless substance users tested for HIV between January 2004 and September 2008, 449 or 5.7 percent tested positive for HIV. According to SAMHSA's Treatment Improvement Protocol booklet, *Substance Abuse Treatment for persons with HIV/AIDS* (2000), this rate is 2.4 percent higher than the national average for homeless substance users. Less than 3 percent of the 449 HIV positive homeless substance users identified through this prevention program reported receiving drug treatment at the time of testing. Only 2 percent reported being in care with local Ryan White service providers at the time of testing. Ryan White service providers are federally funded programs that provide mental health counseling, medication assistance, referrals to medical and dental care, housing subsidies, assistance with SSI benefits, case management, support group services, substance abuse treatment referral, and other services for HIV-positive individuals living below the national poverty level. All 449 HIV-positive substance users identified by RCA, Inc.'s HIV project met the income requirement for services through Ryan White. However, Ryan White requires clients to have government issued identification prior to receiving care. Atlanta's homeless population is notorious for not having ID. Prior to "9/11" a Georgia resident only needed a birth certificate and a social security card or print out of their social security number and a voter registration card or letter from a local homeless advocacy agency (shelter, church, etc.) confirming a person's identity to get a state issued identification. Now the requirement is a state issued ID combined with a birth certificate,

social security card, or social security printout. This barrier, combined with Ryan White's mandate requiring clients to be drug free for at least 30 days prior to receiving care, resulted in close to 100 percent of the 449 HIV-positive substance users identified by RCA, Inc. being denied access to HIV care. This reality has resulted in a homeless community infested with HIV-positive substance users who can not access services; ensuring a constant increase in HIV-infection rates among Atlanta's homeless drug using community. This is further evidence for the need to develop P-BRSS for substance users among Atlanta's homeless community.

Recovery Defined

The fundamental concept of "recovery" continues to increase in its attractiveness though it lacks a singular definition. This is problematic for several reasons. One, it continues to create challenges for substance use treatment programs because they are expected to lead people to recovery but what constitutes recovery for an abstinence based program is very different from what constitutes recovery for medication assisted interventions such as methadone and Buprenorphine programs. Yet, both identify as treatment programs. For researchers, this ambiguity can be problematic because they are challenged in their attempts to determine the effectiveness of recovery programs when there is no single definition? And, what about RCOs? Are they not responsible for promoting "multiple pathways to recovery?" Does this imply that recovery has "multiple" meanings? The absence of a solid definition for the term recovery makes it difficult for clinicians, administrators, and researchers alike to provide and evaluate services in a manner that has clearly defined outcomes (White, 2009).

It is clear that the word "recovery" has different connotations for different people. There was a time not long ago when the phrase "recovery" was a concept almost exclusively associated with the 12-step recovery programs such as AA and NA (White, 2006). Individuals in 12-step

recovery know what this term means and to them they need no one else to define it for them. It is an important part of their lives and many believe that they could not live or survive without it. To members of 12-step programs, recovery means to abstain from all mind altering and mood changing chemicals and this is best achieved through regular support group attendance, relying on a “higher power, and reaching out to help others (Narcotics Anonymous, 2008). However, there are others who believe that recovery goes well beyond just mere abstinence but instead is an experience of bountiful new life and an ongoing process of growth, self-change, and reclaiming oneself (Laudet, 2007).

Recovery has become a phrase that is now used in faith-based terms, medicine assisted terms, and to describe gender-specific as well as culturally-specific programs. There are even national advocacy organizations such as “Faces and Voices of Recovery,” and local organizations such as Recovery Consultants of Atlanta, Inc. that utilize this word in their titles. SAMHSA has an annual “recovery” month event and President George W. Bush in 2003 created “Access to Recovery,” a 100 million dollar innovative substance abuse treatment program that several states continue to benefit from today (Clay, 2003). CSAT’s White Paper, the *Guiding Principles and Elements of Recovery-Oriented Systems of Care* (2007), provides a comprehensive list of qualities of recovery. They are:

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.

- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

In September 2006, the California-based treatment facility owned and operated by Betty Ford, wife of former President Gerald Ford, invited a group of 12 concerned and experienced individuals (referred to as the consensus panel) to come together for a 2-day conference for the purpose of developing a definition of recovery that could be shared among the treatment and recovery fields of America (Consensus Panel, 2006). This group included individuals from the addiction treatment field, policy makers, addiction researchers, as well as individuals who self-identified as “persons in addiction recovery.” This consensus reaching process began by having the members review and discuss existing articles on recovery. These articles were presented to the consensus panel and they debated the merits of each. At the end of the 2-day conference a working draft definition was formulated and circulated for additional comments from the panel members. This 2-day conference was recorded in a special article in the *Journal on Substance Abuse Treatment* entitled “*What is recovery? A working definition from the Betty Ford Institute*” written by the consensus panel. The panel defined recovery in the following manner:

Recovery from substance dependence is a voluntarily maintained lifestyle characterized by *sobriety, personal health, and citizenship*.

Sobriety refers to abstinence from alcohol and all other non-prescribed drugs. This criterion is considered to be primary and necessary for a recovery lifestyle. Evidence indicates that for formerly dependent individuals, sobriety is most reliably achieved through the practice of abstinence from alcohol and all other drugs of abuse. Early sobriety = 1–11 months; sustained sobriety = 1–5 years; stable sobriety = 5 years or more.

Personal health refers to improved quality of personal life as defined and measured by validated instruments such as the physical health, psychological health, independence, and spirituality scales of the World Health Organization QOL instrument.

Citizenship refers to living with regard and respect for those around you as defined and measured by validated instruments such as the social function and environment scales of the WHO-QOL instrument. Criteria 2 and 3 extend sobriety into the broader concept of recovery. *Personal health* and *citizenship* are often achieved and sustained through peer support groups such as AA and practices consistent with the 12 steps and 12 traditions (Consensus Panel, 2006).

In spite of this great work and consensus based definition, the term “recovery” continues its ambiguity. Among addiction researchers, treatment providers, evaluators, state and federal policy makers, there is still no single definition for this term. Indeed, it is probably safe to say that only among the 12-step recovery community is there a consensus for this definition.

The peer-based recovery movement uses the phrase “recovery” synonymous with the terms “addiction recovery” or “recovery from drug and/or alcohol addiction” (Whiters, Santibanez, Dennison, & Clark, 2010). Though this does very little to eliminate the vagueness of this phrase, it at least adds an adjective that makes this term specific to addiction, or more specifically drug and alcohol addiction.

The lack of an accepted definition for the concept of recovery contributes significantly to the variation in reported outcomes of addiction treatment (Laudet, 2007). In other words, because the ambiguity of this term remains constant, treatment professionals differ in their methods for measuring its outcome. The stigma associated with drug and alcohol dependence will continue unabated until the meaning of recovery is clarified, the prevalence of recovery across cultural communities is confirmed by scientists, and a large cadre of individuals and families in long-term recovery stand to offer themselves as living proof of the transformative power of recovery (White, 2009).

Faith-Based Recovery

One of the most significant breakthroughs in the modern addictions treatment/recovery movement is the recognition and legitimization of multiple pathways to recovery from substance use. These pathways can be broadly categorized into 2 different frameworks: traditional or 12-step (also referred to as spiritual approach) or faith-based approach. Interest in faith-based frameworks of recovery are peaking due to the dramatic growth of recovery ministries and President George W. Bush's implementation of Access to Recovery (ATR); a national program that promoted the inclusion of faith-based interventions in the treatment of Americans impacted by addiction. In the journal article *Faith-Based Recovery: Its Historical Roots* (2005) authors White and Whithers state:

The history of faith-based recovery in America originated with the rise of Native American abstinence-based religious and cultural revitalization movements in the 18th and 19th centuries (the Delaware Prophets, Handsome Lake, the Shawnee Prophet, the Kickapoo Prophet, Indian Christian missionaries such as William Apress and George

Copway, the Indian Shaker Church, and the Native American Church). These movements called for a rejection of alcohol and a return to native tribal traditions as a framework for personal recovery and cultural survival. (p. 58)

The rituals (weekly meetings, mutual sharing, utilizing sponsors [someone that the person seeking recovery talks to regularly about how they are feeling and doing in their recovery - referred to as accountability partner in faith-based recovery], etc.) of faith-based recovery are very similar to traditional 12-step recovery with 2 major exceptions: faith-based recovery is based on a particular religious belief and profanity is not allowed in the recovery format. An example of a faith-based program would be Celebrate Recovery, a Christian-based 12-step program founded by Rick Warren at Saddleback Recovery in Southern California (retrieved from website www.celebraterecovery.com on February 2, 2010). This program includes men and women who meet weekly, share mutual concerns, and work to overcome their addictions by enhancing their relationship with Jesus Christ.

Christian specific faith-based recovery programs such as Celebrate Recovery are developed by individuals who rely upon God as the source of their personal recovery (www.celebraterecovery.com). Many of these individuals hold simultaneous memberships in 12-step programs, while others sustain their recovery solely through their religious program. This is not to imply that individuals in traditional 12-step programs do not have strong faith in and/or reliance upon God because many do. However, in faith-based recovery, reliance upon God and belief in a specific religion is the rule as oppose to an option - unlike 12-step recovery where individuals are allowed to choose any object they like as their Higher Power (i.e. the group, their sponsor, God, etc.).

AA's concept of a "Higher Power," an important spiritual component that members believe is necessary for achieving and sustaining long-term recovery, laid the foundation for the beginnings of religious-based recovery. Subsequently, faith-based approaches to addiction recovery continue to increase in recognition and are viewed by many as viable and successful options. An extremely positive outcome resulting from this belief was President George W. Bush's faith-based initiative; a position he took to expand federal funding options to faith institutions that he believed had demonstrated an ability to provide quality services to underserved Americans suffering from addiction and other social ills. This initiative resulted in an increase in the number of religious institutions receiving funding for social programs including addiction recovery programs (Brown, 2003). As a result of faith-based federal funding, we are now witnessing an increase in research-driven exploratory efforts focusing on the success of faith-based programs (White, 2006; Brown, 2003).

Process for Achieving Recovery

Medication and behavioral therapy, especially when combined, are important elements of an overall therapeutic process leading to recovery that often begins with detoxification, followed by treatment and relapse prevention (NIDA, 2002). Easing withdrawal symptoms is important in the initiation of treatment and this is best accomplished through a supervised medical detoxification lasting on average three to seven days, depending on the drug of dependence and the length of use, segueing into a period of clinical intervention, i.e. cognitive behavioral therapy, motivational enhancement therapy, group therapy, etc. What is problematic about this method is that since 1975 treatment costs have continued to escalate (Califano, 2007) and treatment programs have continued to decline (Johnson & Roman, 2003). These realities have

resulted in a marginalizing of the poor and uninsured; resulting in another American service accessible primarily by the privileged. This is additional evidence that justifies the need for the development and implementation of culturally appropriate P-BRSS.

There are many pathways to addiction recovery, however, many people have the perception that the only way or the best way to secure recovery is through a clinical intervention. Some will go as far as to suggest that a clinical intervention within a residential or hospital-based program is compulsory in order to achieve recovery. Albanese & Shaffer (2003) state:

While many elect to recover from addictive disorders on their own, others choose clinical care. Treatment can occur in a variety of settings and represents an array of clinical modalities. A combination of modalities, such as pharmacologic and psychosocial interventions, yields the most favorable treatment outcomes. Nonspecific treatment factors (e.g., empathy and counter transference) also considerably influence treatment outcomes. The treatment process is enhanced when clinicians match clinical interventions with patients' motivation for change and their stage of addiction or recovery. (p. 55)

Because addiction has multiple dimensions and creates so many problems in an individual's life, treating it can be very complex. Effective treatment programs typically incorporate many different components, each directed to a particular aspect of the disorder and its consequences (NIDA, 2002). Addiction treatment must help the individual abstain from and sustain a lifestyle free from drug use, and assist the individual in becoming a productive member of society. Because addiction is a chronic disorder, people do not simply stop using drugs for a few days and become cured. Because of this fact, many substance users require long-term or repeated episodes of care before achieving sustained abstinence and recovery of their lives (White, 2009; White & Kurtz, 2006; White, Kurtz, & Sanders, 2006).

Reducing the risk for relapse is necessary for maintaining ongoing recovery and one way that this is achieved is through client involvement in P-BRSS (Whiters et al., 2010; Collins et al., 2007). Similar to other chronic diseases, episodes of relapse may require a return to treatment. A continuum of care that includes a culturally appropriate treatment regimen—addressing all aspects of an individual's life, such as medical and mental health services—and follow-up options provided through P-BRSS can assist persons in successfully achieving and maintaining a drug-free lifestyle (Whiters et al., 2010; Collins et al., 2007; Clay, 2004; NIDA, 2002).

Peer-based Recovery Support Services

A fundamental underpinning of the peer-led recovery movement is one based on the belief that recovery from addiction manifest through multiple pathways (Whiters, et al., 2010; Collins et al., 2007; White, 2008). These manifestations take place through traditional treatment programs, through 12-step participation, primarily AA and NA, and through faith conversations, particularly Christian and Muslim faiths (White & Whiters, 2005; Bell, 2002; White, 1998). This belief has become the cornerstone of the peer-led recovery movement. It is the anthem on which the model stands. Individuals who believe that addiction recovery is attainable only through traditional treatment or 12-step participation are not appropriate for this movement, nor are they supporters of this concept.

Conventional wisdom makes the assumption that the most effective method for obtaining and sustaining long-term recovery from addiction is through treatment. Albanese & Shaffer (2003) postulate that there are many who experience unassisted recovery but these individuals tend to have milder forms of the disorder and fewer coexisting problems that complicate the recovery process. This is good information for the peer-based recovery movement because many

substance users seeking recovery through the P-BRSS model will never access traditional treatment.

Research has demonstrated that addiction recovery is most effective when supported by social support systems (Chen, 2006; White, 2009). A broad definition for the term “social support” includes the extent to which a person has people in their lives to provide support in one way or another (Chen, 2006). This support could be emotional, spiritual, or monetary (White, 2009). There appears to be a direct relationship between social support and improved health (Chen, 2006; White, 2009). In the peer-based recovery movement, social support networks help apply pressure on individuals, motivating them to adopt healthy behaviors that lead to a reduction in drug use. There are four primary types of social support services that have been identified in the peer reviewed literature as most important for helping to sustain long-term recovery from addiction. They are *emotional support*, *informational support*, *instrumental support*, and *affiliational support* (White, 2009). These are the support systems that RCA, Inc. used to establish its services. As an example, RCA, Inc.’s social entrepreneurial program Recovery at Work (RAW) is an employment program that uses informational support to assist clients with employment. This program also uses emotional support such as recovery coaching to help clients understand the appropriate practices and behaviors for finding and maintaining employment and instrumental support when assisting clients with repairing their criminal records or credit reports. See Table 1.1. These services are used to augment the clients’ involvement in RAW.

Peer Leaders

The concept of peer support is a relatively new phenomenon within the alcohol and substance abuse treatment field (Clay, 2004). The type of P-BRSS referred to in this study were

developed only recently as a result of (1) the continuous closing of treatment programs, subsequently resulting in a lack of access to treatment for the poor and marginalized, (2) the repeated failures of traditional treatment, and (3) the limited focus of 12-step support groups such as AA and NA.

Table 1.1

Social Support Services

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence	Peer mentoring Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	Parenting class Job readiness training Education preparation
Instrumental	Provide concrete assistance to help others accomplish tasks.	Day care for single parents Transportation for clients Help with accessing community health and social support services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers Sports league participation Drug free social events and opportunities

P-BRSS are inexpensive, do not require credentialed facilitators, and are easy to design and implement (Whiters et al., 2010; Collins et al., 2007). P-BRSS are effective at reducing substance use and sustaining long term recovery while and are considerably less expensive than traditional treatment. Because the cost is low CSAT, a component of SAMHSA is very interested in making these interventions widespread (Clay, 2004).

The providers of services within the peer-led recovery movement are referred to as “peers” or “peer leaders.” These are individuals who are recovering from drug and/or alcohol addiction. In the peer-to-peer relationship, the peer leader is the person who is mentally and emotionally stable in their recovery and capable of providing social support services to an individual in a manner that starts the recipient on a path of recovery. As a result of the interaction, both parties benefit: the recipient through recovery and the peer through the good feeling of helping someone.

Self-disclosing personal experiences with addiction and recovery as a means for enhancing the value of the peer-to-peer interaction is an important dimension of being a peer. In other words, it is imperative that the peer leader discloses to the recipient that he or she is a former drug and/or alcohol user as a strategy for gaining their trust and establishing a recovery relationship. This is another principle that separates this movement from traditional treatment because the ethical guidelines of the treatment profession prohibit counselors from disclosing to clients their recovery status (for those who are in recovery), while this disclosure is the very essence of the peer-led movement.

Timeline of Recovery Support Services

During the mid 1990s, CSAT began to recognize the need to bring the addiction recovery community together to become active in the public dialogue surrounding addiction and recovery. In 1998, CSAT implemented the Recovery Community Support Program (RCSP) to help people in recovery, their family members and allies organize themselves and educate their communities about addiction, addiction recovery, and stigma (Clay, 2004). From October 1998 through September 2001, RCSPs funded by CSAT began to mobilize diverse populations of recovering people, focusing their attention on overcoming stigma, educating the public about addiction and

recovery, and contributing ideas to addiction treatment systems. From these first grant projects came the idea of establishing recovery support services as an adjunct to treatment systems (Clay, 2004). As a result of CSAT's establishment of the RCSP, there is now a nationwide group of individuals in recovery serving as "recovery advocates," individuals who speak openly about the value of recovery and the stigma that makes accessing recovery for many a challenging experience (Clay, 2004). In October 2001, CSAT funded 11 new RCSPs across the country, expanding its efforts to reduce stigma and raise awareness around addiction recovery. Each RCSP was funded for five years at \$200,000.00 per year. Recovery Consultants of Atlanta, Inc. was one of the 11 organizations funded in October 2001.

Paradigm Shift

It is reported that the majority of Americans view addiction as crime as opposed to an ailment (Califano, 2007). From October 2001 to September 2002, RCA, Inc.'s advocacy movement was successful at educating a great number of Atlanta residents and government officials on the nature of addiction and the value of addiction recovery, helping to reduce the perception of addiction as a crime. Though RCA, Inc.'s initial mission was to develop a group of well trained advocates and teach them to become spokespersons and advocates for recovery, helping to reduce the stigma associated with addiction and addiction recovery, in October 2002 a paradigm shift occurred, one that would change the RCSP focus from providing advocacy to providing peer-based recovery support services.

CSAT's RCSP were conceptualized during the Clinton/Gore administration. However, under the Bush/Cheney administration, advocacy was viewed as too close to "lobbying," a practice forbidden by recipients of federal grants. Grobman (2005) states:

By law, nonprofits that are 501 (c) (3) organizations may engage in lobbying efforts provided this activity is not “substantial,” but they are prohibited from participating in partisan political activity in support of, or opposition to, any candidate for public office. Organizations exempt under Section 501 (c)(4) of the Internal Revenue Code, on the other hand, may (and do) engage in substantial lobbying activities-often this is their sole purpose-but their donors are not eligible for tax deductions on donations to these organizations. (p. 276)

In October 2002, CSAT changed the name of its addiction advocacy and stigma reduction program from *Recovery Community Support Program* to *Recovery Community Services Program*. Its strategy for saving and preserving the RCSP movement was to change the focus from advocacy to providing P-BRSS. What was challenging about this shift was that there were no existing examples of P-BRSS or empirical support for this intervention; at least not in the addiction recovery field.

Each RCSP was now charged with the responsibility of developing and implementing innovative P-BRSS that would help individuals in need of recovery overcome their addictions. CSAT and SAMHSA believed that this phenomenon would lead to a reduction in drug use among America’s substance using culture, while simultaneously raising awareness of addiction recovery among American citizens. In addition, the RCSPs were now responsible for mobilizing members from their city’s respective addiction recovery community and guiding them in the development of these services. Unlike the treatment movement of the 1980’s, one that was driven by profit, the peer-based movement was founded on a premise that individuals in recovery possess the skill and acumen to develop systems that benefit others in need of services. This was justification for the low to no cost concept.

Offering P-BRSS to individuals seeking recovery from substance use disorders is designed to aid recipients in achieving long term sobriety. P-BRSS offer viable options to recovery for those unable to access treatment. Its fundamental philosophy is grounded in a belief that individuals currently experiencing long-term recovery possess the skills, ability and willingness to develop services that help others, new to recovery, achieve sobriety; thus the phrase “peer-based.” Though little research has been conducted on the effectiveness of this intervention (White, 2009, 2008), the rising societal costs associated with drug abuse and the incessant closing of drug treatment programs mandate an investigation into the usefulness of this practice. This innovative movement has resulted in a radical redirection of how services are provided to individuals, families and communities impacted by substance use.

P-BRSS have been specialized and tailored to meet the needs of Blacks, Native Americans, Hispanics, women, Lesbian, Gay, Bi-sexual, and Transgender (LGBT) communities, offenders, and HIV positive substance users. P-BRSS offered through the RCSPs have proven effective at reducing substance use and sustaining recovery while being offered in an affordable manner; one that ensures that those marginalized by expensive treatment programs can access care. This last point is extremely important because the current socio-economic status of inner-city African American and other ethnic minority substance users marginalizes them and makes accessing traditional treatment for them nearly impossible.

An argument can be made that P-BRSS originated within the inebriate movement of the 1800s; long before the current SAMHSA/CSAT movement began. However, an argument can also be made that these prior movements do not classify as P-BRSS because they were absent of the shared goal of establishing services nationwide and serving populations of addicted people marginalized by the reduction of national treatment programs. The peer-based recovery support

movement of 2002 was very similar to the movement of the 1800's, in that both were created by individuals who are themselves in recovery, and the interventions were offered as free services. The one major difference is the movement in 2002 had a national network; working simultaneously to spread the concept of this model across the nation.

In either case, following is a time-line identified by White (1998) for the use of people in addiction recovery as interventionist for others seeking recovery:

- The use of peers in the addiction recovery and/or in the treatment profession began with recovering people serving as temperance missionaries (1840s-1890s);
- Managers of inebriate homes (1860s-1900);
- Lay alcoholism psychotherapists (1912-1940s);
- Managers of “AA farms” and “AA recovery houses” (1940s-1950s);
- Halfway house managers (1950s - present); and
- Paraprofessional, non- credentialed addiction counselors, credentialed addiction counselors, outreach workers, and case managers (1970s - present).

P-BRSS Linked with Addiction Treatment

According to Clay (2004), there are at least two states (Pennsylvania and Georgia) working to systematically include P-BRSS as part of a reconfigured continuum of addiction treatment services. The inclusion of P-BRSS in each of these states' addiction treatment and recovery programs will help legitimize P-BRSS as interventions that reduce drug use and sustain recovery among substance users.

P-BRSS linked to addiction treatment began to spawn within inebriate homes and asylums during the mid to late 1800s (White, 1998). The Opiate Club, the Goodwin Associations, and addiction cure institutes of the Keeley League, all began to develop between

the 1860s and 1890s (White, 1998). During the 1940s and 1950s, AA “wards” began to “pop-up” in hospitals and therapeutic communities (Leminski, 2001; White, 1998). Halfway houses and self-managed recovery homes such as the Oxford House began to rise in popularity during the 40s and 50s and treatment center volunteers and treatment center “alumni associations” began to evolve as key programs, filling gaps left by the reduction in treatment programs (Leminski, 2001; White, 1998).

During the late 19th century, grass-roots organizations began developing movements and support systems for the purpose of addressing the problems of alcoholism (Leminski, 2001; White, 1998). Quite often, these movements were linked to religious, political, or social organizations. As an example, in the early 1800s, Dr. Billy Clark, a religious leader founded the temperance movement (White, 1998). This movement of white men, believed to be the first of its kind, had as its original goal the transforming of alcoholics into moderate drinkers. Early in the movement, a period between 1800 and 1825, their member’s opinion on moderate drinking changed to a more conservative position advocating complete abstinence from alcohol. This decision was based on years of client observations, concluding with the conviction that no safe drinking for the alcoholic was possible. This shift in philosophy was profound and served as a gateway for current medical positions supporting alcoholism/addiction as an illness, rather than moral deficiencies, characterized by an inability to abstain even when consequences were apparent and severe.

During a period between the mid 1980’s and early 1990’s, literature promoting the need and rationalization for the development of specialized addiction treatment interventions for adolescents, battered and traumatized women, African Americans and other specialty groups began to surface (Sterk, 1999; Longshore, Grills, Annon, Grady, & Rhumel, 1998; White, 1998).

This same body of literature began highlighting the growing number of Americans in need of substance use treatment, while simultaneously recognizing the lack of available treatment access for the poor and underserved. These realities served as the genesis for the movement advocating for the creation of alternative, cost-effective, proven treatment systems.

National Recovery Summit

Promoting the concept of recovery lies at the core of the peer-led movement and fostering the development of recovery-oriented systems of care is its top priority. In support of this movement, in 2005 CSAT convened a National Summit on Recovery. Participants at the summit represented a broad group of stakeholders, policymakers, advocates, recovering individuals, and representatives from diverse ethnic and professional backgrounds. This summit represented the first broad-based national effort to reach a common understanding of the guiding principles of recovery, elements of recovery-oriented systems of care, and definition of recovery. During the summit, seventeen (17) elements of recovery-oriented systems of care emerged from the process. These elements now provide a philosophical and conceptual framework to guide RCOs and other recovery groups offering a shared language for dialog. The elements produced by this group for recovery-oriented systems of care include:

- Recovery Oriented Systems of Care (ROSC) are person-centered;
- They operate best when inclusive of family and other allies;
- They offer individualized and comprehensive services across the recovery lifespan;
- They are systems anchored in the community;
- They support continuity of care;
- They include partnership-consultant relationships;

- They use a strength-based approach;
- They are culturally responsive;
- They are responsive to personal belief systems;
- They are inclusion of the voices and experiences of recovering individuals & their families;
- They represent integrated services;
- They offer system-wide education and training;
- They support ongoing monitoring and outreach;
- They are outcomes driven;
- They are in support of research based interventions; and
- Are adequately and flexibly financed.

Challenges with the Traditional Treatment Model

For the most part, treatment for alcohol and other drug dependencies has historically been in the form of inpatient care, where the client enters a program for a specified amount of time and undergoes various therapeutic experiences that are intended to address his or her substance dependency (Cloud & Granfield, 2001). Since the mid 1940s, the most common intervention for addiction treatment has been based on a model referred to as the “Minnesota Model.” This model, originating out of the state of Minnesota, incorporates a system that begins with a supervised-medical detoxification, lasting three to seven days, and segueing into four weeks or 28 days of psycho-educational treatment, primarily in an inpatient setting (Lemanski, 2001). In the book *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (1998), White opens the chapter on the “Minnesota Model” with the following:

This chapter will explore how the state of Minnesota came to be known as “The Land of Ten Thousand Treatment Centers”- a state that as early as 1981 had more than 3,800 residential beds for the treatment of addiction. But this story is not just a local one. In the late 1940s and early 1950s, a number of events coalesced to shape an approach to addiction treatment that was replicated widely throughout the United States and beyond. This is the story of the birth and spread of the “Minnesota Model” of “chemical dependency” treatment. (p.199)

What became known as the Minnesota Model originally evolved from the development of AA in Minnesota in the late 1940s and early 1950s and from three new alcohol treatment programs: Pioneer House, Hazelden, and Willmar State (Mental) Hospitals’ alcohol treatment program (Borkman, Kaskutas, Owen, 2007; Lemanski, 2001). Pioneer House used recovering AA members as staff and relied on the principles and practices of AA as the basis of a residential stay in an informal atmosphere with a minimum of rules and regimentation (Borkman et al., 2007). Hazelden, initiated by a businessman, clergy and recovering AA member, was directed by the recovering AA member but was envisioned to be for the alcoholics of the “professional class” prior to losing their jobs and families because of their alcoholism. Hazelden targeted middle and upper class clients who could pay for treatment out of pocket because there was no insurance coverage for alcohol treatment during this time (Borkman et al., 2007). The third approach at the Willmar State Hospital in Minnesota was led by professionals (a psychologist named Dan Anderson and a psychiatrist named Nelson Bradley) who had recognized their limitations in effecting change in their alcoholic patients and had asked recovering AA members from the community for assistance; it was suggested that they look at the Pioneer House and Hazelden programs (Borkman et al., 2007).

Though the Minnesota Model included little to no empirical support, its methods or versions of its methods spread across America like wildfire and have set the trend for the way that addiction treatment is provided today. In spite of the fact that there is still little to no empirical support for this intervention, it is still perceived by many, including individuals who work as treatment professionals, as the best method for providing treatment and recovery support for substance users.

Addiction in America is currently being treated as if it were an acute care disorder as opposed to the chronic ailment that it is (White, 2009). The Minnesota Model and its replicates are evidence of this. As a result, many individuals seeking treatment and their families have been misled into believing that at the end of 28 days of treatment, a cure or complete healing will take place. While there are those who complete treatment and never abuse substances again as well as those who complete treatment and reduce their frequency of substance use to a manageable level, addiction continues to be a disease for which there is no known cure (Cloud & Granfield, 2001). Therefore, it must be treated daily in order to keep it “arrested” because it continues to progress even when dormant. Cloud & Granfield (2001) state:

The disease theory of addiction postulates that if you are addicted, you have inherited or, through your substance misuse, have contracted the disease of addiction. This view also assumes that the disease of addiction that you have is progressive, that it gets worse over time. It also postulates that there is no real cure for your disease, even if you stop using alcohol and other drugs. It suggests that during abstinence your disease is merely in a dormant state of remission and will return to its active state if you take a drink or use a mind-altering drug. In other words, the disease view maintains that you are an alcoholic and/or an addict and will be one for the rest of your life. (p. 42)

While there are also those of a religious persuasion who argue that God alone can and does heal individuals from addiction, as well as those who argue that addiction is not a disease but instead a moral deficiency, developers of the peer-based recovery movement take no position on this debate. Their position is that there are multiple pathways to recovery including religious conversions and individuals who stop using without any intervention at all. However, they continue with their belief that includes a position that no method or approach is better than the other. All methods are viable and they each play a vital role in the recovery movement.

Many treatment professionals take the position that individuals who are able to overcome an addiction without receiving treatment through traditional models are individuals who meet DSM IV criteria for abuse but not dependence. Several will continue by suggesting that complete sobriety is achievable only through traditional treatment programs (Albanese & Shaffer, 2003). However, there is evidence that close to 5 million Americans sustain their recovery from drug and alcohol use through regular participation in 12-step fellowships (NSDUH, 2009). And though the majority of people in 12-step recovery began their recovery in traditional treatment (White, 2006), many were able to begin their recovery without first accessing traditional treatment or after having failed treatment experiences (McLellan et al., 2003; Cloud & Granfield, 2001). This would imply that treatment is not mandatory for achieving recovery.

Supporters of the peer-based recovery movement take the position that many substance users, including those who are dependent, find recovery through recovery support services. These services can be offered as adjuncts to traditional treatment or independent of traditional treatment. What makes them special is that they are generally free to low cost and developed by people in recovery for people seeking recovery. Many are gender and culturally specific, while others are based on faith principles. One of the most important elements of P-BRSS is that they

take a chronic care approach to treating addiction which means that services are available to clients for as long as they need or want them; unlike treatment which is finite in its approach.

The Minnesota Model and its replicates continue their existence throughout America and in other parts of the world. Some of its modifications include a shift from a twenty-eight day treatment paradigm to an evidenced based position that promotes a minimum of 90 days of treatment in order to secure the highest outcomes (McLellan et al., 2003). During the mid 1990s, a second discovery occurred in the traditional treatment model. It was discovered that outpatient treatment, when compared to residential treatment, provided the client received a minimum of 90 days of treatment, was equally effective, resulting in the same outcomes, and considerably less expensive (Cloud & Granfield, 2001; White, 2009). For insurance companies and other third-party payers, this contribution to the science-based literature was important because it augmented their decision to discontinue paying for residential treatment when outpatient treatment was deemed equally successful and considerably less expensive. The insurance industry viewed this as a cost-saving measure that would ultimately result in more individuals receiving addiction treatment and care (Cloud & Granfield, 2001). However, what occurred was a reduction in both public and private treatment programs because many of the residential programs closed as a result of this shift in payment (Roman & Johnson, 2003). Because there are more people in need of treatment than there are treatment programs (NSDUH, 2009), the closing of public or private programs contributed to the ongoing problems and lack of services for substance users. The lack of access to treatment for marginalized substance users resulting from the change in the way insurance companies reimbursed for treatment services has contributed to the development of alternate approaches to care, namely P-BRSS.

The acute care approach to addiction treatment has failed a great number of people, but this is not its only problem. Another major dilemma facing the Minnesota Model is the method by which outcomes are measured. For example, when a person completes traditional treatment and returns to substance use this is considered justification for the treatment provider to recommend to the client that they return to treatment for follow-up care. Within the culture of traditional treatment this is referred to as a failed treatment episode or relapse. This recommendation to return to treatment is offered in spite of the fact that 60 percent of individuals seeking recovery from addiction through traditional treatment relapse within the first 12 months, with 80 percent of the relapse occurring within the first 90 days (White, 2006a; 2006b). This statistical data applies only to the small number of individuals who are able to access treatment - this does not include those who present for care at institutions such as churches, synagogues, or mosques that are not counted in the treatment census. How are these individuals labeled when they fail their first, second, third or 100th time at trying to find sobriety? Are they also labeled failures? In the peer-based recovery movement, no one is labeled a failure. Everyone is labeled a success when they present for care. Individuals are allowed to define for themselves what their recovery successes are. For example, if a client presents with a dilemma of smoking crack daily and through a P-BRSS intervention is able to reduce their crack use to less than everyday, even if it is only reduced to 6 days as opposed to 7, this is considered a success. This type of praise leads to increased esteem among clients and builds within their psyche a belief that if they can reduce their drug use to 6 days as opposed to 7, then maybe they can get it down to 5 days, then 4, then 3, and so on and so forth. The P-BRSS movement utilizes a “strengths-based approach” as oppose to the failed system approach of the traditional treatment movement. This is another

characteristic of the peer-based recovery movement that sets it apart from other forms of recovery programs.

Purpose of the Study

This case study had two primary purposes. This first was to describe, examine, and discuss the specific events in the initial five year history of Recovery Consultants of Atlanta, Inc. (RCA, Inc.). RCA, Inc. is a federally funded, faith- and peer-based addiction Recovery Community Organization (RCO). Its services and programs are designed to lead homeless substance users into recovery and raise their HIV awareness.

Covering the period October 2001 to September 2006, this study examined the development of RCA, Inc., its subsequent implementation of services, and the significant role of its founder. Within this purpose the author identified the following research questions:

1. What was the motivation behind the creation of this organization and its services?
2. What is the theoretical foundation that supports these services?
3. What role did individuals in addiction recovery play in the development, implementation, and evaluation of these services?
4. What justification was there for the inclusion of the faith community?
5. How does the effectiveness of these services compare to traditional treatment approaches and how is this measured?

A secondary but equally important purpose of this study was to develop a template in which MSW graduates could follow a step-by-step process for replicating RCA, Inc. or similar community-based organizations. This template was designed to assist master level social workers who believe they are capable of managing a successful non-profit organization but lack the acumen for developing one on their own. This study will not only provide them with the knowledge necessary for creating a successful program but also the encouragement and

motivation by detailing the successful experiences of RCA, Inc. and its founding member, an MSW graduate.

It may be possible for a reader of this study to formulate an impression that the devastating effect of alcohol and drug use on Atlanta's African American homeless population is the primary problem being addressed in this study. This conclusion would not be difficult to reach since the effects of addiction on Black America, including Atlanta's predominately Black communities, are highlighted throughout this study. As an example of this destruction, author White (1998) states:

Alcohol and other intoxicating drugs disempower African-American men and women, undermine the African-American family, and drain energy and resources from the African-American community. Alcohol and other drugs serve as tools of suppression and oppression by anesthetizing Black rage and replacing political action with personal self-destruction. Alcohol and other drug use contribute to the systematic incarceration of young Black men. Alcohol and other drugs are tools of genocide that destroy Black lives through suicide, homicide, accident and disease. (p. 304-305)

Schiele (2000) also emphasizes this point while clearly referencing impoverished African Americans who suffer from the daily demise of drug abuse and oppression:

The victims or targets of political economic oppression, generally speaking, are those groups in society whose physical, mental (i.e., value orientations), or behavioral attributes are used to construct barriers to the degree of power and wealth they can attain in society. For these groups, political-economic oppression places them at significant risk of abusing drugs by ensuring that they experience poverty or material deprivation

disproportionately, as well as the hopelessness and despair that accompanies that deprivation. (p. 98-99)

However, the real issue addressed in this study focuses on the need to develop and implement proficient and efficient Peer-based Recovery Support Services (P-BRSS) that are designed to reduce addiction and its related ailments such as HIV, viral hepatitis, criminality, ongoing homelessness, poverty, and deprivation among Atlanta's homeless African American substance using population. A secondary issue highlighted throughout this study focuses on enhancing public awareness regarding addiction and recovery and influencing public opinion in a way that ultimately reduces the stigma and negative public perceptions of addiction and addiction recovery.

P-BRSS are non-professional and non-clinical services that are developed by individuals recovering from substance use for individuals new to addiction recovery or in search of addiction recovery (Whiters, Santibanez, Dennison, & Clark, 2010; White, 2009; Collins, Whiters, & Braithwaite, 2007). These services are generally free to low cost and are not intended to compete with traditional drug and alcohol treatment, but instead are intended to work either independent of or as adjuncts to treatment programs. What makes P-BRSS unique is that they are developed by people in recovery who use their "personal experiences with addiction and recovery" as their primary credential for offering these services. Their motivation derives from a need to create alternative methods of recovery for individuals who will either never access traditional treatment or who have had several failed experiences with traditional treatment. White (2009) defines P-BRSS in the following way:

Peer-based recovery support is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-

related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery. (p. 16)

The term peer-based implies that services and support systems come from the personal experiences of individuals who have lived through the horrors of drug and/or alcohol addiction and are now experiencing the freedom and promise of peace that comes from recovery. Peer-based also implies that the recovering individual shares similar characteristics and experiences with those that they serve, including similarities in age, gender, ethnicity, sexual orientation, prison experiences, etc. White (2009) states, “individuals seeking recovery may receive peer support within a therapy group led by a professional therapist within an addiction treatment organization, but this would not be considered a peer-based recovery support service” (p. 16). A fundamental requirement of this movement is that the “majority of services” developed and implemented are done so by individuals in recovery. This study postulates that P-BRSS, developed by individuals in addiction recovery, specifically for homeless African-American substance users in need of addiction recovery, offered in collaboration with Black churches, and based on Afrocentric principles, are extremely effective methods for reducing substance use and sustaining long-term recovery among this group. A thorough examination of this study will reveal a peer-based movement orchestrated by individuals in recovery who developed an innovative group of services based on the above referenced theories and principles resulting in an increase in the quality of life for both the recipients and service providers.

CHAPTER II

Literature Review

The participants in this study were African American adult men and women from inner-city Atlanta. More than 60 percent reported having less than a high school diploma and more than 75 percent reported being unemployed at the time they were receiving services.

A longitudinal African American cohort study, focusing on drug use among New York City African Americans, began in 1988 with a sample size of 668. By 1993, the sample size was down to 347, with moving away, death, and incarceration being the major factors in this attrition (Brunswick, 1999). RCA, Inc.'s attrition rate or dropout rate was considerably lower than this percentage during the 5 years of this study, but still high, at around 30%. RCA, Inc. attributes this rate to their peer-based transitional housing project that provided safe housing for the clients while they pursued their recovery. Were it not for this program, their attrition rate would have been much larger.

A review of the literature focusing on the peer-based recovery support services produced three peer-reviewed journal articles supporting these endeavors, including two co-written by the author of this study (Collins et al., 2007) and (Whiters et al., 2010). A third journal article, co-written by the author as well, focusing on faith-based peer support services, was also identified (White & Whiters, 2005). Though there is little empirical evidence validating the effectiveness of P-BRSS (White, 2006), contributing to its lack of acceptance by treatment providers and other allied health professions, this intervention is still viewed by many among the 12-step and

faith-based recovery communities as a viable option to and augmentation of traditional treatment systems.

Support for this chapter derived from searches of electronic bibliographic databases (EBSCOhost, Galileo, PsychInfo, PubMed, etc.). Other sources such as books on addiction and recovery and Federal websites and newsletters were also used to provide support for this study. Using keywords related to addiction recovery, a computerized search of social work, health, and addictions journals and newsletters was conducted. Many relevant journal articles and studies were identified.

Within the past 10 years, research supporting Recovery-Oriented Systems of Care (ROSC), a conceptual framework that describes and coordinates the delivery of care for individuals with substance use disorders, has begun to emerge. ROSC are networks of community-based organizations, treatment programs, and individuals in recovery that coordinate a wide spectrum of services designed to enhance recovery among substance users (Clay, 2004). Although states and communities are implementing a variety of services and activities to create ROSC (Whiters et al., 2010; White, 2009), there is minimal research in peer-reviewed journals that examines the framework and effectiveness of this intervention. In spite of this deficiency, this chapter is still able to highlight the research from the addictions recovery field supporting the ROSC model.

An article focusing on peer-based recovery housing was identified, (Jason, L.A., Olson, B.D., Ferrari, J.R., Layne, A, Davis, M.I., & Alvarez, J., 2007). An article focusing on peer-support services for traumatized substance using women was also identified (Fearday & Cape, 2004), but its claim to be a peer-based project is suspect because all of the services appear to be developed by professionals, though an advisory council of women in recovery contributed to this

process. This of course is a fundamental violation of the peer-based movement which states that all services need to be developed for people in recovery by people in recovery (Whiters et al., 2010; White, 2009; White & Whiters, 2005). An article was discovered that focused on a mutual aid support system among a group of recovering social work professors, most of who identify as members of AA. Another research article produced a peer support system among recovering nurses and one for medical doctors as well. An article published in the 2007 edition of the *Journal of Groups in Addiction & Recovery* focused on a group of college students who created their own support program while they simultaneously pursued their degrees and attended AA daily. However, only three articles identified within this literature review focused clearly on peer-to-peer support programs promoting recovery from drug and alcohol addiction. Of the remaining journal articles discovered that could qualify as discussions surrounding addiction support systems of a peer-based nature, most focused primarily on the 12-step movement of Alcoholics Anonymous (Cleveland, Harris, Baker, Herbert, & Dean, 2007; Galanter, M., 2007; Laudet, A., 2007b; Litzke & Glazer, 2004). This appears to make sense since the AA approach to “aftercare” for drug and alcohol treatment appears to provide the most favorable outcomes for most groups of substance users (Brown et al., 2002). However, the peer support movement of today is different from the 12-step recovery movement started by AA, with examples of this difference highlighted throughout this study.

Beginning in 2006, a host of scholarly literature specific to the peer-based addiction recovery movement began to surface. However, this group of literature was being developed by a sole source, author William White. During this time period, White produced 6 books on this subject. They are:

- (1) *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement* (White, 2006).
- (2) *Linking Addiction Treatment & Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches* (White & Kurtz, 2006).
- (3) *Recovery Management* (White, Kurt, Sanders, 2006).
- (4) *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment toward a Recovery-Oriented System of Care* (White, 2007).
- (5) *Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices* (White, 2008).
- (6) *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation* (White, 2009).

Each of these publications was preceded by White's famous book, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (1998).

As a result of the rising substance related health and societal problems associated with the closing of public and private treatment centers, one might suspect a more significant research interest of an exploratory or empirical nature on peer-based addiction support services, but such was not the case. Because of this reality, this literature review will often reference the history of addiction mutual aid societies, a first cousin and predecessor to the peer-to-peer support concept, and their historical tract and direct connection to today's phenomena, Peer-Based Recovery Support Services.

An additional source of related literature can be found among the mental health movement. An article focusing on peer support services within the mental health recovery movement (Carpenter, 2002) was discovered by this researcher. Starting in the early 1990s, the

mental health field focused on the process of recovery to guide decisions related to the mental health system (Carpenter, 2002). A recovery mental health model puts the locus of control and decision-making in the hands of the person who has the mental health condition (Tomes). Carpenter (2002) continues by describing the recovery vision and the community support system perspective that provided a framework and essential services of a recovery-oriented system of care for mental health disorders. Much has been written about the success peers in recovery from mental health have had in providing support services to others overcoming or recovering from mental illness. However, as similar as the movements are, recovering from addiction is quite different than recovering from mental illness and it is this position that has led to the decision not to use literature from the mental health movement as support or augmentation to the peer-based addiction recovery movement.

Addiction recovery mutual aid societies have a rich history spanning the 18th and 19th centuries. Though different from today's movement of peer-based support services the similarities are striking. First of all, the mutual aid movement was created by individuals who were themselves afflicted by addiction (White, 1998). In an attempt to overcome their addictions they organized support groups. These were isolated groups with no national connections. Today's movement consists of a national effort that is maintained by having a common goal that stretches across 11 CSAT funded RCOs (Clay, 2004). Though each RCO operates independently, maintaining true autonomy, they share a common bond. This commonality is the rationale for the development of this movement which was to fill the "gaps in service" left by the closing of addiction treatment programs. This commonness is what makes P-BRSS different from the mutual aid society movement of the 18th and 19th century.

The first mutual aid societies were the Native American “recovery circles,” an abstinence-based healing and religious/cultural revitalization movement of the early 1800s (Lemanski, 2001; White, 1998). Next came the fraternal temperance society, a movement of affluent white men created during the mid 1800s (Lemanski, 2001; White, 1998). Since these early movements, trails have been blazed for subsequent abstinence based recovery groups. In 1870, we witnessed the development of the Drunkard’s Club, a mutual aid group for men attempting to find peace from a life free from drink (Lemanski, 2001; White, 1998). In 1914, a similar group with a similar focus, the United Order of Ex-Boozers was founded, and in the late 1920’s we witnessed the development of the Washingtonians, a very successful group of white men who formed a support system to help them remain free from alcohol (Lemanski, 2001; White, 1998). Then came the alcohol prohibition of the 1920s, a legislative attempt to end alcohol consumption and its related problems. This alcohol reform movement in combination with the depression of the 1930s placed a strain on America’s alcoholics (White, 1998). However, as evidenced by reports from this period, “boot-legging,” an illegal operation that made obtaining “corn-whiskey” and other alcoholic beverages possible was in full effect. Thus, the need to develop and sustain mutual aid groups for those impacted by the problem of alcohol continued (White, 1998).

In 1935, America would experience a recovery movement that would ultimately redefine our world’s view of alcoholism and the alcoholic. It would be a movement unlike any that preceded it or any that would follow. More men, women and children, regardless of race, creed, religion or lack of religion (though the original members of this movement were all white men), would find recovery from addiction in this movement than in all of the earlier programs combined (Lemanski, 2001). This movement clearly articulated addiction as a disease and

identified the substance user as in ill person as opposed to one suffering from a moral deficiency. It was this movement that would shake the world and shame science by demonstrating that recovery from addiction was possible through a fundamental practice of having one person in recovery serving as the sole interventionist for one attempting to recover. This practice would become known as “the therapeutic value of one alcoholic helping another” and would serve as the foundation for a worldwide fellowship that today boast of a membership of more than 1.7 million members and can be found in more than 150 countries (Cloud, Ziegler, & Blondell, 2004). This program would become known around the world as Alcoholics Anonymous.

CHAPTER III

Methodology

Examining RCA, Inc. and its place among Atlanta-based Recovery Community Organizations providing services to homeless, African American substance users, was the objective of this study. This goal was best achieved through by the means of qualitative research. Consideration was given to both quantitative and mixed method approaches, but it was determined by this researcher that utilizing the qualitative research method would return the best results for this study.

Qualitative techniques of observation and interviewing have gained increasing popularity among social work practitioners (Royce, Thyer, Padgett, & Logan, 2001). Afrocentric social work research recognizes the importance of both quantitative and qualitative modes of observation in explaining and interpreting human behavior and in advancing societies (Schiele, 2000). However, of the two, Afrocentric social work research claims that qualitative methods are better structured to elicit the deeper and more authentic experiences of human beings (Asante, 1990, as reported in Schiele, 2000). The decision to use qualitative rather than quantitative research methods during this study was based largely Schiele's revelation. This researcher believed it was necessary to take an Afrocentric qualitative research approach in order to clearly detail the events of this organization. Further support for this method can be found in the following Rubin and Babbie (2001) quote:

Qualitative research methods emphasize the depth of understanding associated with idiographic concerns. They attempt to tap the deeper meanings of particular human

experiences and are intended to generate theoretically richer observations that are not easily reduced to numbers. (p. 44)

Taking a qualitative approach to inquiry has an extremely rich tradition in social work research and is a widely used method for achieving the goals and outcomes set forth in this study (Padgett, 1998). Qualitative methods are capable of capturing the subtle nuances of program drift that quantitative measures cannot (Royce, et al., 2001). During the 1990s, qualitative research designs became more visible, particularly among social workers and educators (Creswell, 2005; Rubin, & Babbie, 2001; Padgett, 1998). Padgett (1998) reports that a growing number of doctoral programs in social work have eagerly embraced qualitative methods and that social work students should have the opportunity to learn about qualitative research and be encouraged to embark on research careers based on qualitative methods.

As stated earlier, a focus of this study was to describe specific events in the history of a federally funded RCO. It is important to restate this purpose because of the following point stated by Creswell (2003):

Qualitative research is fundamentally interpretive. This means that the researcher makes an interpretation of the data. This includes developing a description of an individual or setting, analyzing data for themes or categories, and finally making an interpretation or drawing conclusions about its meaning personally and theoretically, stating the lessons learned, and offering further questions to be asked. It also means that the researcher filters the data through a personal lens that is situated in a specific sociopolitical and historical moment. (p. 182).

Using an inquisitive and investigative qualitative strategy, this author set out to discover the rich experience of an innovative, peer-led, faith-based recovery program, highlighting both

its successes and challenges. In examining the five year history of this organization, the researcher set out to discover the ins and outs of the organization, including its development, implementation, and sustainability strategies. The qualitative research method utilized in this study is a historical case study analysis. Stoecker (2005) describes qualitative research as a method that typically involves interviews, documents or observation, with only a few cases involved, that the researcher then interprets rather than counts. He continues by pointing out that “communities, organizations, families and other social groups are favorite objects of those defined as qualitative researchers” (p. 6). This qualitative researcher has identified one organization for examination: Recovery Consultants of Atlanta, Inc.

Qualitative research has been described as an extremely effective methodology for describing major and important events from a historical perspective (Merriam, 2001; Padgett, 1998). Padgett continues by stating that, “for all of their demands, qualitative methods can provide the most rewarding experience a researcher will have” (p.1). The goal of qualitative research is to grow in understanding of situations and their uniqueness; recognizing the roles they play in cultural and social environments. The qualitative researcher “views social phenomena holistically . . . this explains why qualitative research studies appear as broad, panoramic views rather than micro-analyses” (Cresswell, 2003, p.182).

Merriam (2001) refers to qualitative research as “an umbrella term that has numerous variations” (p.10). Creswell (2003) reports that there are five primary methods of qualitative research. These include:

- (1) *Ethnographies*, a method employed by researchers that focuses on the study of human society and culture. Common techniques for gathering data using this

variation include interviewing, documentary analysis, examination of life histories, and creating diaries;

- (2) *Grounded theory*, a specific method that focuses on the development of a theory at the end of the research;
- (3) *Case study*, a method that is employed to gain an in-depth understanding of a situation, program, event, activity, process, or one or more individuals . . . the interest is in the process rather than the outcomes, in context rather than a specific variable, in discovery rather than confirmation;
- (4) *Phenomenological* research where the focus is primarily on the examining of an experience's structure. This method is concerned with an assumption that there is an essence or essences to shared experience; and
- (5) *Narrative* research, a form of inquiry in which the researcher studies the lives of individuals and asks one or more individuals to provide stories about their lives.

The qualitative research variation chosen for this study is a case study of a peer-led, faith-based Recovery Community Organization. Single case studies have a long and honorable history in qualitative research (Padgett, 1998).

Padgett (1998) reports there are 3 basic modes of data collection in qualitative research. They include (a) observation (of the respondent, the setting, and oneself); (b) interviewing, and (c) review of documents or archival materials. The primary data collection method used for this study includes a 5 year observation of daily activities as recorded and reported by the researcher. An additional data collection method includes the examination of archival materials. These materials include annual reports, newsletters, brochures, and grant applications.

This case study highlights a five year history of specific events in the day-to-day operations of a peer-based RCO. Merriam (2001) states that “qualitative case studies can be characterized as being particularistic, descriptive, and heuristic” (p. 29). This means that it is very appropriate to use qualitative methods in this study because case studies can focus on a particular organization, such as Recovery Consultants of Atlanta, Inc., focusing specifically on its development, its historical perspective, and the services provided. In addition, this method is appropriate because it is holistic and allows for a deep discussion of a set of specific theoretical foundations: community organizing; social action; and Afrocentrism, while simultaneously allowing for a rich discussion on the Christian principles included in the foundation of all of the organization’s services. A very refreshing point of this study was the ease in which the qualitative research methods, particularly case study methods, matched the researcher’s goal - which was to capture in rich detail the nuances of this exciting organization and its innovative services.

Study Design

Designing a research study utilizing qualitative research methods is very different than designing a study using quantitative methods. Cresswell (2003) states that:

Qualitative procedures stand in stark contrast to the methods of quantitative research.

Qualitative inquiry employs different knowledge claims, strategies of inquiry, and methods of data collection and analysis. Although the processes are similar, qualitative procedures rely on text and image data, have unique steps in data analysis, and draw on diverse strategies of inquiry. (p. 179)

This single case study was designed by choosing a sole source and examining its development, implementation, and history over a five-year period.

Padgett (1998) describes qualitative research as a very powerful tooling for inquiring about the lives and socio-historical context in which we live. Padgett continues by stating that the key to understanding qualitative research is to focus on the ideas that meaning is socially constructed by individuals in interaction with their world. The goal of qualitative research is to understand situations as being unique, a part of a particular context in a socio-political-cultural environment. The qualitative researcher focuses on interactions, examining what is going on to get to the understanding from the perspective of those being studied (Royce et al., 2001).

It appears that there is no right or wrong way of conducting a case study so long as its principles are based in the tenants of qualitative research. When conducting a qualitative research study, researchers have at their disposal multiple sources including artifacts, interviews, observations and printed materials that can be included in important aspects of the study and several of these sources can be identified through archival methods, published reports, news articles, photographs, etc. (Creswell, 2003).

Cresswell (2003) identifies eight rationales for choosing a qualitative research method. They include (1) it allows the researcher to investigate how or what happens in a particular topic or interest; (2) it allows for an exploration into a topic for which variables regarding the phenomena are not clear; (3) it yields a detailed view of the problem being studied; (4) it provides an arena where individuals may be studied in their natural environment so that the problem is understood within its cultural context; (5) it brings the researcher into the study through the use of a first-person literary writing style; (6) it is appropriate for researchers who have sufficient time and resources to engage in the site to gain rich contextual data; (7) the appropriateness of qualitative research to a study requires that the audience of the research be accepting of this approach; and (8) the researcher becomes an active learner, telling the story of

the participants from their perspective and experience. Analyzing results for a case study tend to lend more towards observation than statistical analysis.

Wolcott (2001) believes that “qualitative analysis, used in the narrower sense, follows standard procedures for observing, measuring, and communicating with others about the nature of what is “there,” the reality of the everyday world as we experience it” (p.33). Based on this comment, this researcher employed the practice of observing, collecting, and examining documents and artifacts. Records, documents, and Federal sources each provided invaluable information that was included in this study. Government newsletters also provided rich and invaluable sources for this study, as well as quarterly and annual reports prepared for the funding source by RCA, Inc. Reports of programs developed and services offered as well as documents advertising or promoting services are other additional sources that were analyzed for in this study.

Sample Selection

In qualitative research, purposeful sampling is the method used to describe the various sampling strategies favored by qualitative evaluators (Royce et al., 2001; Cresswell, 2003). This method of sampling allows the researcher to choose the specific subject, resulting in the best information to answer the research questions.

A qualitative research design was used to document the implementation process of Recovery Consultants of Atlanta, Inc. A case study of RCA, Inc. was used to adequately document the specific events in the history of this federally funded addiction Recovery Community Organization, RCA, Inc. (n=1). Convenience sampling was the method used for this study.

Design Rational

Case study research has been described as an extremely effective methodology for describing major and important events from a historical perspective (Merriam, 2001; Padgett, 1998). Padgett continues by stating that, “for all of their demands, qualitative methods can provide the most rewarding experience a researcher will have” (p.1). A single-case research study design was selected for this study because qualitative research focuses on a holistic understanding of the historical nature of an event, organization, person, or group of people. In the case of this study, RCA, Inc. in a specific timeframe was studied. This case represents the entire study in which the facts that were gathered were derived from various sources and conclusions drawn based on those data.

Data Collection

The data collection steps [for a qualitative research study] include setting the boundaries for the study, collecting information through unstructured (or semi-structured) observations and interviews, documents, and visual materials, as well as establishing the protocol for recording information (Cresswell, 2003). Archival documents in the form of agency reports, meeting minutes, official filings, grant applications, brochures and announcements, government newsletters, and other related documents were collected for this study. Each document was carefully evaluated for its utility and accuracy before it was included for review. Documents were coalesced and used in a manner that painted a wonderful picture and resulted in a rich description in the history of RCA, Inc.

Data Analysis

For qualitative evaluators, units of analysis typically refer to individuals (staff, clients, etc.), but they may also include agencies, group homes, hospitals, or any other settings that are

arenas of human activity organized around a particular program (Royce et al., 2001). Cresswell (2003) identifies six steps for analyzing qualitative data. These steps are:

(1) *Organize and Prepare* the data for analysis; (2) *Read* through all data; (3) *Begin detailed analysis with a coding process*; (4) *Use the coding process to generate a description* of the setting or people as well as categories or themes for analysis; (5) Advance how the description and themes will be represented in the qualitative narrative; and (6) A final step in data analysis involves making an *interpretation or meaning* of the data.

A data analysis protocol was developed for this case study to enhance the quality of the research. A chronology of events was generated in order to illuminate major events of each phase of the development of RCA, Inc. Data was grouped in the following phases: Phase 1: Conception and Development; Phase 2: Implementation; and Phase 3: Sustainability. Archival data was then gathered and categorized into these time frames for analysis.

Limitations of Data and Research Design

An overall limitation of quality research is that the sampling strategy chosen, convenience sampling, is “undoubtedly the easiest approach, since it implies doing little more than taking advantage of cases at hand” (Royce et al., p. 92). Royce continues by stating that “the evaluator should be aware – this method is least purposeful and least likely to yield rich information” (p. 92).

The focus of this research design is to provide rich data and discussion of findings as it pertains to a single phenomenon. However, in general, single-case studies can not be generalized to represent any particular group, organization, or population. In addition, much of the information collected during this study was retrospective data and limited to memory and/or recollections of past events. During the conception and planning phase of RCA, Inc. no one

foresaw that the information documented would someday be used for a research study, therefore it is possible that some notes may not have been transcribed accurately and there is the possibility that some documents were misplaced or never recorded. This was a major threat to the quality of data available for analysis.

CHAPTER IV

Theoretical Framework

Dow and McDonald (2003) define theory as “a relatively coherent set of ideas for explaining human behavior” (p. 198). Theory is vital in shaping social work research programs and social work interventions (Dow & McDonald, 2003). As a practice-based profession, social work pursues the four major functions that theory does: description of phenomena; explanation of the causes of the phenomena; prediction of events including the outcome of interventions; and control and management of change (Rubin & Babbie, 2001). As it relates to P-BRSS, the phenomenon is:

- (1) *18 million Americans in need of treatment* services will never receive the help they need;
- (2) *Cause of phenomenon:* escalating cost, closing of treatment programs and stigma associated with addiction and recovery;
- (3) *Prediction:* a significant number of individuals will live half butchered lives or die needlessly from addiction or spend many years incarcerated because they will not access the support services they need leading to recovery from their addiction;
and
- (4) *Control and management:* an ongoing evaluation of its effectiveness must be carried out by experienced researchers in order to maximize the effectiveness of these interventions.

It is important to identify appropriate theoretical frameworks when formulating interventions and or social support services for individuals seeking recovery from addiction. Combining the theories of Community Development and its related theories of Social Planning/Social Action with Afrocentrism within a faith-based or more specific a Christian-based recovery support program is the theoretical framework of this study.

Different theories present different advantages and challenges. A critical examination of the integration of theories occurs throughout this chapter. Special attention was given to the appropriateness of utilizing the chosen theories within an African American and faith-based framework. Can European models of community development combined with Afrocentric principles survive within an African American recovery group? This question was asked and answered throughout this chapter. This was an important concern that required a deep philosophical examination prior to selecting the “perfect” theoretical framework for this study. Was it appropriate to attempt to integrate European-centered and Afro-centered theories and synergize them with the faith-based principles of Christianity, or would the development of an Afrocentric Community Building theory have been more appropriate - one that would have fused the principles of all three theories?

Community Development Theory

As a result of a careful and thorough examination of the literature including empirical studies on substance use treatment and recovery, this researcher has determined that the addiction recovery movement contains elements from the following theories: community development, social action, and Afrocentric theories. The community development model with its focus on organizing community residents at the grass-roots level, identifying clear purposes with identifiable outcome measures, training and educating members in the skills of leadership,

and emphasizing grass-roots involvement in the development of leaders (Rivera & Erlich, 1995; Rothman, Erlich, & Tropman, 1995; & Tropman, Erlich, & Rothman, 2001), are all elements fundamentally important to the recovery community. In addition, the social action model and its focus on identifying skilled and credentialed leaders to serve as forerunners for the movement (Rivera, & Erlich, 1995; Rothman et al., 1995; & Tropman et al., 2001) is an extremely exciting revelation as well. Though the peer-based movement has enjoyed success with members of the recovering community serving as leaders, the idea of including credentialed individuals, educated in skills aimed at interacting with lawmakers and policymakers is a good strategy. And finally, the decision to combine multiple theories while focusing on individualizing interventions so that clients could make their own choices regarding interventions was deemed extremely valuable in shaping RCA, Inc.'s peer-based recovery program.

It is important for social work students to learn how to articulate and identify appropriate theories for practice and research purposes. The community development model provides an easy to follow step by step plan for identifying communities in need, issues of concern, and an action plan for reaching goals. It also provides a clear understanding for the need to identify leaders capable of comprehending the essence of this theory. However, it also places the recovery community in a dilemma because its strategies and requirements exceed the capabilities of many among. This is because 67 percent of those served by RCA, Inc., during the period 2001- 2006, reported having less than a high school diploma (RCA, Inc. Annual report, dated January 2007). It is not a discouraging dilemma though but instead one that demonstrates the value of education, experience, and partnerships. Members of the recovering community must come to realize that in order to build real advocacy groups and peer-based support services that they must be willing to combine formal learning experiences with their recovery experiences.

The daily principles practiced by many in recovery that are designed to sustain their recovery such as patience, perseverance, faith and honesty, are the same principles required in order to obtain high school equivalency diplomas and other formal learning degrees. An unfortunate reality for people in recovery is that in today's world, formal degrees appear to be more valuable than recovery experiences. This implies that many of America's recovery communities are absent of individuals with the necessary experience to establish advocacy movements or P-BRSS. Unless recovering individuals with the acumen to comprehend theoretical frameworks are identified, recruited and trained, the movement will struggle in reaching its goals. The key to the success of the recovery movement is to develop and embrace theoretical frameworks that teach and educate members how to sustain the movement without losing its essence – the fact that it is encompassed of people in recovery working for and serving people in recovery – many of whom lack formal degrees or high levels of education (Collins et al, 2007).

Tropman et al. (2001) describes community development as an effort to mobilize people who are directly affected by a community condition (that is, the “victims,” the unaffiliated, the unorganized, and the nonparticipating) into groups and organizations to enable them to take action on the social problems and issues that concern them. Barker (2005) defines community development as the efforts made by professionals and community residents to enhance the social bonds among members of the community, motivate the citizens for self-help, develop responsible local leadership, and create or revitalize local institutions. In a broader definition Rivera and Erlich (1995) state that community development “rests heavily on a series of developmental processes, but the tangible, concrete end-product goals are equally significant, and development can not take place unless process and product goals are equally valued and operationalized” (p. 231). Rivera and Erlich continue by stating “community development

requires timely realized products that have both short- and long-term accomplishments and impact” (p. 231). Identifying, selecting and organizing members of the recovery community, segueing into training sessions, resulting in the development of leaders and advocates capable of interacting and influencing policy makers, concluding with the development and implementation of peer-based support systems, resulting in measurable benefits for recipients, were the extremely important principles and practices necessary for the development of the faith-based and Afrocentric recovery movement instituted at Recovery Consultants of Atlanta, Inc.

Burdine, Felix, & Wendel (2002) define community development as a term that grows from several different roots - public health, social work, and economic development, among others. Broadly defined, it is a process by which a community identifies its needs and resources, develops an agenda with goals and objectives, then builds the capacity to plan and take action to address these needs and enhance community well-being. Burdine et al. continue by stating that terms community organization, community mobilization and community-based are also used by some to describe similar approaches. These approaches are not mutually exclusive and the subtle differences are not important. What is important, however, is to appreciate the underlying philosophy and strategic application that are subsets of these ideas which are useful in helping a community to increase and employ their capacity for local health status improvement.

Carlton-LaNey (2001) reports that many disenfranchised groups have found ways to solve their own problems without governmental intervention or support. Through local community approaches to problem solving, many marginal groups have been empowered to seek unique solutions that are specifically tailored to their needs, resources, and aims. Community building is critical to the success of such approaches. Carlton-LaNey continues by stating that

community organizing around substance abuse issues is a responsibility for community residents most impacted by this ailment, including the substance users who are viewed as the primary culprits of this dilemma. Authors MacMaster, Jones, Rasch, Crawford, Thompson, & Sanders (2007) take the position that the Black church must take and maintain a lead position in addressing addiction and its related ailments such as HIV and hepatitis if the Black community is to be restored to its vibrant position as a place for learning and nurturing the Black family. This is because the Black church continues to be the leading provider of social support services in the Black community (Brown, 2003).

Each of these positions are consistent and totally in line with the mission and vision of RCA, Inc. Though RCA, Inc. received funding for its project, its method for addressing its issues rested solely with its members. People in addiction recovery were empowered and spiritually guided to develop services that improved the lives of residents and the community as a whole.

Organizing communities for the sake of combating addiction raises a troubling question. Why are there so many people in need of a reconditioning of their minds in order to learn how to live and participate in society? Is there any way to influence this process fundamentally, at an earlier point in people's lives? How does the idea of addiction prevention in pre-school sound? At best, why don't we start providing prevention education in elementary schools? These approaches may help to eliminate the need or at least reduce significantly the need for community mobilization around addiction recovery.

Consistent involvement and attendance in 12-step support groups such as AA and NA is evidence that the ability for organizing exist among members of the recovery community. The 12-step support group practice of identifying members, usually with senior recovery status, to serve as leaders responsible for negotiating meeting space, paying rent, organizing clean-up and

maintenance crews, and preparing for and carrying out regularly scheduled meetings, is further evidence of the existence of potential leaders among this community. However, a challenge identified very early in this process was with identifying leaders to serve as peers in the recovery project. Studies indicate that African American drug users are significantly less likely than White users to have received treatment for illicit drug use and less likely than either White or Hispanic users to believe they would benefit from it (Longshore, et al., 1998). Individuals receiving treatment prior to the beginning of their recovery process report a lower rate of relapse within the first year than those who receive no treatment prior to the process (White & Kurtz, 2006). Because many of the potential leaders for RCA, Inc.'s program originated within populations of African Americans who had not received treatment prior to their pursuit of recovery, RCA, Inc. established a policy that set at a minimum of 1 year of recovery prior to becoming a leader within their recovery project. This would help to reduce the risk of their leaders relapsing while providing services as peers.

Social Action/Social Planning Model

Social planning is one of the methods of social work practice (Barker, 2005). It includes systematic procedures to achieve predetermined types of socioeconomic structures and to manage social change rationally (Barker, 2005). These procedures usually include designating some individual or organization to collect the facts, delineate alternative courses of action, and make recommendations to those empowered to implement them (Barker). A more academic description of social planning is offered by Rothman et al. (1995): social planning is a technical process of problem solving regarding substantive social problems, such as delinquency, housing and mental health. This particular orientation to planning is data-driven and conceives of

carefully calibrated change being rooted in social science thinking and empirical objectivity (unlike other existing forms of planning that are more political and emergent).

Social planning has gradually usurped social action as the primary function of [community based organizations] (Poole & Colby, 2002). It “presupposes that change in a complex modern environment requires expert planners who, through the exercise of technical competencies-including the ability to gather and analyze quantitative data and to maneuver large bureaucratic organizations-are needed to improve social conditions” (Rothman as reported in Poole & Colby, 2002).

Community organizing ordinarily implies social action and sometimes includes neighborhood work involving self-help strategies, but it excludes social planning/policy development approaches (Poole & Colby, 2002). Social planning is the policy component of community development. Its purpose is to prepare individuals for interaction with legislatures for the purpose of influencing policy. However, “social planning usually fails to embrace grassroots organizing efforts (Poole & Colby; p. 28). This last point presented a challenge for RCA, Inc.’s recovery project.

The social planning model’s focus on highly skilled and highly educated leadership was problematic for the recovery community project given what had been previously discussed regarding the educational and skill level of the majority of its members. The challenge was met head on and addressed by RCA, Inc. Though many from the identified recovery community were without high school diplomas and formal degrees, a concerted effort was made to identify leaders with good oral and written skills and some college experience to serve as leaders of the project, provided they met the minimum recovery clean time which was 1 year. These individuals would have as their primary objective interacting with local legislators, SAMHSA

officials, and preparing reports. These responsibilities evolved into roles that were as important as the role of the peers providing services to clients.

Organizing the recovery community was founded on the premise that its members would be grounded in the grassroots movement. The social planning component relied less on grassroots involvement and more on the leadership component. However, it would have been a major error if RCA, Inc. had totally ruled out the value of this model because of this flaw. The social planning model's emphasis on preparing individuals, albeit fairly educated individuals, for interaction with key legislators was an important element that was near and dear to the hearts of the leaders of this project. Therefore, it was imperative RCA, Inc. embrace this practice and learn the strategies necessary for teaching individuals with low levels of education how to use it to their advantage. Two important questions precede this last suggestion: (1) could non-degreed individuals learn this practice and (2) if so, what was the process? The answer is absolutely and the process was similar to their recovery practice, they learned this process a day-at-a-time, a project-at-a-time, and a moment-at-a-time. This process is now intricately engraved in the day-to-day operation of RCA, Inc.

The social planning model and its emphasis on political involvement presented a second dilemma for the recovery community. Several recovery community members with their fixations for remaining apolitical found this position in total contrast with their beliefs. Recovery support groups of a 12-step nature support a position of advocacy without being involved in politics. The social planning model appeared to be suggesting involvement in politics: a clear no-no for many of our recovering leaders who were also involved in the 12-step recovery community.

Poulin (2005) believes that social action activities are aimed at challenging inequalities, confronting decision makers, and empowering people to change unjust conditions. Its practices

include selecting a community of focus, building relationships within the community, providing training for community members, mentoring key people to listen for themes within their community, facilitating the critical thinking process to identify action solutions, facilitating the implementation of action solutions, and finally, evaluating the process and its impact (Poulin, 2005). All of the referenced characteristics of this model seem appropriate for inclusion in the development of peer-based support services. Organizing the recovery community begins with identifying common themes and concerns of its members. A subsequent step may include identifying potential leaders for organizing the masses and developing strategies for meeting objectives. Developing educational programs for leaders and general membership taking into consideration the barriers presented by low levels of education and income are also important. Identifying leaders most capable of influencing policy makers and influential stakeholders is paramount. All of these principles, practices and concepts can be developed using the social action model. However, the question becomes can this model work for a group of recovery substance users, most of whom are African American, fluent in Ebonics, and surrounded by a world of poverty? This author believes so and evidence of this is made clear in the following Johnson (1998) quote:

This approach [social action organizing] has been a part of the social work response to human need from its earliest days. Jane Addams engaged in organizing for social action as he advocated for improved social conditions. More recently it has been used by Saul Alinsky and Richard Cloward and was widely used during the period of social unrest in the 1960s. Since that time a theory base has been developing that supports the use of this approach to organizing oppressed peoples. It focuses on changing the societal power base or calls for basic institutional change. Alinsky's theory is sometimes referred to as a

grassroots approach. It begins with people who see themselves as victims, not with professionals who decide what is needed. (p. 310)

The social planning model offered insightful strategies for organizing communities, and held many advantages that could be considered beneficial to the development of RCA, Inc.'s addiction peer-based recovery support model. The many challenges associated with incorporating this theory in the development of peer-based support services clearly did not discourage RCA, Inc. from working to ensure achievement of the obvious benefits: an organized recovery community developing and providing services that would free thousands of homeless, African American substance users from the misery of active addiction.

Choice Theory

An equally exciting theory found in the addiction recovery movement is Choice Theory, a component of the Reality Therapy (Jackson, 2003). Choice Theory is effective for counseling persons with addictive disorders and is a very effective strategy for assisting in sustaining long-term recovery among substance abusers (Howatt, 2003). It is not used often with clients in the early stages of addiction recovery (Howatt, 2003). Early recovery is defined as a period of time directly after a person chooses to begin a process for overcoming their addiction; generally lasting for the first year (Howatt, 2003). Choice theory is a strengths-based approach to recovery, where service recipients are encouraged to focus and build on their strengths while minimizing activities deemed as shortcomings that may lead to relapse to drug use. An example may include attending 12-step and/or faith-based support groups during the first ninety days of recovery as a strength, and avoiding all friends and family members who are still using drugs and/or alcohol as a strategy for reducing a shortcoming. This theory demonstrates the ability of clients to succeed by giving them tasks within their capabilities. Born out of the Reality Therapy

theoretical framework, choice theory is designed to give clients options in the behaviors they choose after clearly identifying the benefits and consequences associated with their choices (Howatt, 2003; Jackson, 2003). It can easily serve as a core recovery tool because it promotes an important theme for recovery – the power of choice (Howatt, 2003; Jackson, 2003;). Though this theory appeared to be an appropriate theory for inclusion in this study, the researcher choose not to use it because further examination revealed that this theory is best suited for individuals who have completed treatment and are at a point in their recovery where sustainability is the primary focus. Most of the clients at RCA, Inc. were clients whose focus was learning the basic tenets for remaining drug and alcohol free.

Its focus on intervening with clients early in the recovery process strengthens its appropriateness for this peer led intervention. In addition to assisting clients in identifying both positive and negative choices regarding their substance use, this theory also helps in the development of a fundamental plan that clients can follow that point out to them the consequences or benefits that comes by the way of choices. Organizing members of the recovery community for the purpose of developing peer-based support services, educating participants on the realities of their actions and behaviors, and providing them with the education for making appropriate choices - choices that lead to a reduction in self-destructive behaviors, is an example of the power of this particular theory. It provides a perfect adjunct to the theories used throughout this study.

Afrocentric Community Building Model

Support for culturally specific addiction treatment programs - created by African American social scientists for the purpose of researching African Americans - can be identified throughout the peer-reviewed literature (Whiters et al., 2010; Collins et al., 2007; Bell, 2002,

Sanders 2002, Schiele, 2000, White 1998;). A position taken by Schiele (2000) clearly supports a community strengths approach for dealing with addiction; one predicated on “African-centered precepts and values.”

A culturally specific theoretical framework serving as an offspring of both community development and community building is the Afrocentric Community-Building model (Freeman, 2000). It is generic to community building and is inclusive of Afrocentric principles and practices, incorporating elements of spirituality, culture, and African rituals in its practice (Freeman). Afrocentric, also referred to as Afrocentrism or Afrocentricity is a process of internalizing values that emphasize love of self, building on one’s awareness of traditional African development, principles and practices, and using the pride that comes from these beliefs as motivation for building one’s esteem, evidenced through one’s commitment to improving the lives and villages of Africans across the Diaspora (Bell, 2002; Schiele, 2000; Akbar, 1998; Asante, 1996). Martin & Martin (2002) profess that Afrocentrism has inspired a great deal of activity directed toward strengthening the Black community and that it is in harmony with other trends and movements in the Black community that seek to claim African heritage for the use it may have toward uplifting the Black community. Carlton LaNey (2001) takes the position that:

Education and training for future social workers must include content that will help students embrace a multicultural perspective that includes an Afrocentric paradigm. They can learn much from African American social welfare pioneers like Margaret Murray Washington, whose example can guide them toward a deeper appreciation for human diversity and gender issues. Based on systems perspective, individuals and groups are interdependent, and as long as one racial group is politically, socially, or economically enslaved, the entire nation can never experience authentic freedom. Hence, the social

work profession is challenged not only to teach skills, but also to prepare others to “uplift a people.” (p. 71)

Afrocentrism continues to grow as a favorite intervention for addressing drug use in the African American community (Schiele, 2000; Longshore, et al., 1998). This is due in part to its common philosophical theme of focusing on communalism and collective support (Longshore, et al., 1998). This theme separates it from western practice of individualism and focus on self. Renowned African American scholars (Schiele, 2000; Akbar, 1998; Asante, 1996) postulate that the incessant use of drugs and alcohol by African Americans can be directly attributed to their consistent move towards individualism. In support of this position and as a strategy for healing the African American community Schiele (2000) suggests a macro intervention aimed at “healing” the entire community and eradicating it of illicit drugs. This position is inline with that of the peer-based recovery community which supports recovery not just for the individual but for the family and community as well. Only when all three components are whole will real recovery began to occur. This is why the Afrocentric theory is imperative to a peer-based recovery movement that focuses its efforts on homeless, African American substance users.

In recent years, researchers and community advocates have cited a need for drug abuse interventions that build on the cultural resources of the African American community (Schiele, 2000; Longshore et al., 1998). Interventions of this nature are said to be congruent with African American culture, delivered in ways that affirm the heritage, rights, and responsibilities of African Americans, and using interaction styles, symbols, and values shared by members of that group (Longshore, et al., 1998). The Engagement Project is a culturally congruent intervention in which Afrocentric concepts are applied in an intervention for African American drug users. The intervention is lead by a counselor and a former drug user (essential for meeting the peer-to-peer

concept) constituting a dyad. The intervention includes an in-depth review of the Nguzo Saba or the 7 principles of Kwanzaa, a formulation of seven values and principles leading to solid principles the drug user can practice on a daily basis to help him or her remain drug free. The daily and repetitious practice of the Nguzo Saba principles restores the user to their rightful place as heirs of mother earth segueing into a rejuvenated person who demonstrates a lifestyle consistent with values that honor family and community.

Several principles from the previously referenced theories can be found incorporated in this model. The social action principle for “clearly identifying both a community and issue of focus” is extremely important for this movement. We have identified a community: African Americans who self disclose a need for recovery from addiction residing in inner-city Atlanta; and, the issue is: an absence of advocates and mentors to guide and direct this group as well as an insufficient number of support services available to assist them in their recovery. As it relates to the first issue, identifying professionals from among the recovery community who will serve as leaders - a social planning principle –was a major issue for RCA, Inc. When taking into the account the characteristics of members of the recovery community, individuals with extensive criminal histories and low levels of education, identifying potential leaders with the technical expertise required for effective social planning was difficult. This was the case even though many members from the recovery community had college experience. But the number of those who did was considerably lower than the number of those who did not. And, the recovery community members recruited to be a part of this movement who did have college degrees were not interested in participating in delivering support systems to inner-city substance users or participate in grass-roots recovery events because they were more comfortable being involved in suburban recovery. RCA, Inc. took a more effective strategy and identified and recruited inner-

city recovering substance users and developed them as leaders in the movement. Educating and mentoring potential leaders is another principle of the social action model. Identifying potential leaders with the ability to learn the technical expertise required for effective social planning is a current RCA, Inc. strategy for developing future recovery leaders.

A critical argument against the inclusion of the social planning model is that its leadership focuses more on social planners and professionals than grass-roots individuals; a limited resource among the African American recovery community. This social planning focus appeared to originate during the mid 1900s when federal funding of community based groups began to grow, requiring individuals with specific skills, generally higher than that of a grass-roots person to lead the organization (Rothman, Erlich, & Tropman, 1995).

Having access to appropriate technology and staff that create the service product is an important component of the social planning model (Rothman et al., 1995). Recovery community organizations can not spearhead innovations in social planning unless they have the technical capacity to do so. Having a large number of members with the skills to negotiate appropriate technology has been problematic for the recovering community. Technological skills as simple as meeting space negotiation and board meeting development is limited to a minority group of recovering members. In a study conducted of 30 community based neighborhood centers, it was discovered that not one had a community advisory board and very little if any input from citizens in the community centered on decision making (Rothman et al., 1995). These realities, in most cases, apply to the recovery community as well.

The African-Centered Community Building paradigm builds on the community development and related models by adding a specific focus on African Americans (Freeman, 2000). It utilizes principles and practices from the social action model but also takes into

consideration the reality that some of the practices from European-centered models are not appropriate or relevant to Black people (Freeman, 2000). Within the African-Centered community building movement there is a principle that states that the community or the village and not one individual or serves as the leader (Asante, 1996). This, in part, is in contrast with the principles of the traditional community development and social planning models, both of which encourage professionals to serve as leaders of the movement. In addition, neither of these models reference God or a reliance on a higher power as a source of strength or guidance (Schiele, 2000; Asante, 1996). In the Afrocentric paradigm, God is the foundation and this source must be present in order for the model to operate properly (Schiele, 2000; Asante, 1996). Black people who self identify as being in recovery often time credit God solely and entirely for their recovery. However, this position, almost to a fault, has led to an attitude among many Blacks in recovery that the only work they must do to sustain their recovery and advance in life is to maintain their strong belief and reliance upon God. The Afrocentric paradigm encourages belief and reliance on God but at the same time holds members accountable for their actions; particularly as it relates to building positive relationships and working to improve their communities (Schiele, 2000; Asante, 1996). In other words just confessing a belief in God is not enough. Individuals involved in this movement must spend a considerable amount of time working to improve the lives of their community and its residents.

The Afrocentric community development model operated by RCA, Inc. not only offered African Americans in recovery the opportunity to develop and implement support services, but also the opportunity to embrace their heritage and culture and use the pride that came from this as a tool for developing additional services that benefited their people, community and themselves. This is the theoretical framework that served as the underpinning for the peer-based

recovery support services provided by RCA, Inc. This theory is most appropriate and highly recommended as the underpinning for the development of an African-centered peer-based recovery support movement.

During the process of identifying the appropriate theoretical frameworks for this project, much thought went into the appropriateness of integrating these theories and principles. The process included lengthy discussions with members from a local grass-roots advocacy group of recovering African Americans experienced in influencing law makers for the purpose of establishing favorable policies related to drug and alcohol treatment and prevention. Their input was invaluable and weighed heavily on the decision to synergize the community organizing and Afrocentric theories, while simultaneously encompassing the faith-based principles of Christianity. These discussions opened the door for the development of a peer-based addiction support system designed to offer interventions that would reduce drug use, criminal activity, and HIV infection, while increasing social and family interaction among African American substance users.

What more appropriate theory to begin the work of organizing the recovery community than community organizing. All of the ingredients were in place to begin this process.

- (1) *The group was present:* individuals in addiction recovery who because of their own personal recovery believed they were being led by a higher power to create programs that would help end the misery of addiction running rampant among Atlanta's homeless substance using community; and
- (2) *The problem was apparent:* traditional drug treatment was becoming difficult to access and essentially obsolete. Publicly funded treatment programs, those most accessible by marginalized substance users from low socio-economic status were

becoming a thing of the past. Fewer and fewer treatment options for the poor were becoming the norm; not only for Atlanta, but for most of the country. Plus, several homeless substance users in Atlanta had already experienced multiple failed attempts with the traditional model of treatment and its poor outcomes for people of color. In addition, there were several suffering substance users among this group who had no earthly idea how to access treatment or recovery.

This was all the motivation necessary to begin the process of organizing individuals in recovery who would take on the responsibility of developing services that would help organize and empower homeless substance users.

As reported previously in this study both public and private treatment programs continue to close across the country. Though there are some government funded residential treatment programs in Atlanta (Saint Judes, Mary Hall Freedom House, Another Chance, Recovery Consultants of Atlanta, Inc., Salvation Army, and Jefferson Place) where homeless substance users can go for care, the primary mode of treatment available for this target group is outpatient. Outpatient treatment is problematic for homeless people. A basic tenant of social work is to meet the client where he or she is. Homeless substance users are generally seeking a place to live and food to eat not outpatient drug treatment. Organizing homeless substance users around this issue was the point of origin for Recovery Consultants of Atlanta, Inc.

Faith-Base Principle of Christianity in Addiction Recovery

Approximately two-thirds of African American clergy and more than 80 percent of African Americans in general believe that churches should be eligible to receive government funding for social support services (Brown, 2003). The faith-based principle of Christianity included in the foundation of RCA, Inc. was born out of the reality that the Black church always

has and continues to be the leading provider of social support services (temporary shelter, clothing closets, food banks, GED, senior citizen programs, etc.) in the African American community; particularly among the homeless (Schiele, 2000; Carlton-LaNey, 2001; Bell, 2002; Martin & Martin, 2002; Brown, 2003).

Historically, the Black church has held a prominent role in providing substance use care and treatment to homeless substance users (Bell, 2002). White & Sanders (2002) reveal this wonderful moment in the history of the Black church's involvement in the recovery movement:

In 1845 Frederick Douglass signed a pledge of abstinence and went on to lead the movement to abolish slavery in America. Douglass also played a critical role in the "colored temperance movement" via his assertion that the sobriety of black people was essential to their liberation and assumption of full citizenship. Today, African Americans in recovery and their family members are again moving beyond their own healing to confront the larger alcohol and drug problems of their communities. They are organizing within their churches and creating new grassroots recovery-advocacy and social-action organizations. (p. 53)

Glide Memorial United Methodist Church in San Francisco, home of the first ever National Association of Black Social Workers (NABSW) meeting, under the leadership of the charismatic Reverend Cecil Williams, in the late 1980s, launched one of the first culturally specific drug treatment programs for African Americans (White, 1998). Williams' program used Afrocentric metaphors (slavery, genocide) to conceptualize addiction, called upon individuals to discover the power within themselves, reframed religious/spiritual concepts (rebirth, resurrection) to support addiction recovery, and strengthened and expanded the traditional extended family and kinship network within the Black community to support addiction recovery. This model would go on to

serve as the foundation for subsequent Christian-based addiction recovery programs with an Afrocentric flavor.

Another example of a faith-based approach to addressing addiction in Black America occurred in 1930, under the leadership of the Honorable Elijah Muhammad and the Nation of Islam (White, 1998). White reports that leaders of the Nation of Islam, utilizing a religious intervention, engaged black men addicted to drugs and alcohol and successfully converted them to men of honor, glory, and values, with the most famous conversion of all being a “cocaine snorting, reefer-smoking, drug-dealing hustler known as “Detroit Red” (p. 238). He would later become one of our world’s greatest leaders – his name is was El Hajj Malik El-Shabazz, better known as Malcolm X.

Faith-based peer-based support groups, modeled after traditional 12-step support groups such as AA and NA, with a Christian twist, are rising in popularity, particularly within the African American community. These support groups copy 12-step formats with two exceptions: (1) they do not allow the use of profanity at their meetings; and (2) participants are encouraged to speak openly and often about God. This author has labeled this a *Christ-centered, Afrocentric Approach* to peer-based support services. Peer-leaders utilizing this approach are generally grounded in Christianity and are proud of their African heritage. Bell (2002) refers to leaders of this group as “culturally immersed Afrocentrics . . . well educated, articulate, and self-confident” (p. 58). Bell (2002) continues by describing this group as “grounded in Christianity and meeting their personal needs in an exclusive African American context” (p. 60-61).

A position taken by Schiele (2000) clearly supports a community strengths approach for dealing with addiction, one predicated on “African-centered precepts and values” (p. 134). Schiele (2000) states “living in impoverished environments combined with drug abuse are

assurances that Black people will remain contained and controlled” (p. 99). Minorities, including blacks, have a higher prevalence of substance abuse than other Americans because they are disproportionately concentrated in central cities (U. S. Department of Health and Human Services [HHS], 1998). Schiele (2000) states that an Afrocentric perspective declares drug abuse in Black communities as a mechanism that prevents oppressed people from rising up and eliminating the very system that has them oppressed. The Afrocentric paradigm takes the position that oppressed Black people are responsible for developing systems that free them from racist and oppressing environments. This is the same principle that serves as the basis for the *Christ-centered, Afrocentric Approach* to peer-based support services. Given this reality, African-centered “faith believers” in recovery are responsible for developing support systems that benefit others suffering from addiction, regardless of their religion, lack of religion, or ethnicity, though in the case of RCA, Inc., more than 97 percent of the clients served were African American (Whiters et al., 2010). Biblical scriptures, historical African and African American analysis, and real-life events depicting oppressed people rising against evil must be referenced and used as guiding principles and practices for the *Christ-centered, Afrocentric* recovery movement. This approach mandates believers in recovery to live by spiritual principles while simultaneously providing services to populations of hurting people. Their personal recovery from addiction adds credibility to their practice and allows them access to suffering individuals where others, not in recovery, have failed. The *Christ-centered, Afrocentric Approach* teaches that the greatest reward God provides a person in recovery is the gift of using one’s own experiences, including the experience of being of African descent, to benefit others. Individuals who are part of this movement realize how close they are to being in the same predicament as many of the persons they are responsible for helping. This is often exemplified in

the recovery quote, “But for the Grace of God, there go I.” This reality serves as a constant reminder and motivator, making the *Christ-centered, Afrocentric Approach* to providing peer-based support services an extremely rewarding and valuable experience.

History of Organizing the Recovery Community

During the late 19th century, grass-roots organizations began developing movements and support systems for the purpose of addressing the problems of alcoholism (White, 1998). Quite often, these movements were linked to religious, political or social organizations. As an example, in the early 1800s, Dr. Billy Clark, a religious leader founded the temperance movement (White, 1998). This movement of white men, believed to be the first of its kind, had as its original goal the transforming of alcoholics into moderate drinkers. Early in the movement, a period between 1800 and 1825, their member’s opinion on moderate drinking changed to a more conservative position advocating complete abstinence from alcohol (White, 1998). This decision was based on years of client observations, concluding with the conviction that no safe drinking for the alcoholic was possible.

In October 1998, more than 100 years post the addiction treatment movement, CSAT and SAMHSA created the RCSPs. CSAT/SAMHSA believed that this cost-effective phenomenon would lead to a reduction in drug use, while helping to sustain long-term recovery among our nation’s substance users.

This profound paradigm shift has resulted in a radical redirection of how services are provided to individuals, families and communities impacted by substance use. Peer-based support services offered through the RCSPs are evolving as proven methods and are offered at low to no costs. This last point is extremely important because the current socio-economic status of inner-city African American and other ethnic minority substance users marginalizes them and

makes accessing traditional treatment nearly impossible to afford (Hohman, & Butt, 2001; Sterk, 1999; Longshore, et al., 1998; Morrell, 1996).

The pattern of macro relationships to micro practice is very apparent in the community organizing model (Rothman et al., 1995; Rivera & Erlich, 1995). Social work education with its focus on interventions specific to communities, more than adequately prepares its students for employment opportunities in the addiction treatment field (Rothman et al., 1995). Each of the previously identified theories clearly state the need for and value of involvement of skilled and educated community residents in the development of community movements. Throughout this study low levels of education and low socioeconomic status among members of the African American recovery community are highlighted. This reality leads to the conclusion that individuals outside of the recovery community, such as social work professionals, need be identified and recruited to “assist” in the development of this movement. A strategy that RCA, Inc. used was to identify members of the recovery community, who as a result of their recovery, have been able to obtain formal degrees, and motivate these individuals to become involved in this movement as leaders.

CHAPTER V

Formation of the Organization

This chapter summarizes the major events in the development of what is now known as Recovery Consultants of Atlanta, Inc. (RCA). Prior to the creation of RCA, Inc., there was a precursor program, Ujima Recovery Project, hereinafter referred to as “Ujima,” that laid the foundation for the concept of RCA, Inc. Ujima was a peer-based transitional housing program. Its fundamental mission was to provide a safe living environment for both men and women in early addiction recovery, assisting them in establishing and sustaining long-term recovery (see Appendix A).

Ujima is a Swahili term that means “collective work and responsibility.” It is the third of seven principles found in the African American holiday KWANZAA. KWANZAA was founded by Dr. Maulana Karenga, a Professor of African Studies at California State University-Long Beach (Asante, 1988). KWANZAA is celebrated by many in America and offers a cultural message which speaks to the best of what it means to be African American. KWANZAA is designed to enhance the cultural spirits of African Americans and teach them how to build on the strength of their African history and heritage (Asante, 1998). In keeping with the spirit of “collective work and responsibility,” the Ujima program had four primary goals:

- (1) to create a recovery transitional housing program that would provide a safe and drug free living environment for men and women in early addiction recovery;

- (2) to create an accountability system which would ensure that residents of Ujima attend recovery support groups such as Alcoholics Anonymous or Narcotics Anonymous daily;
- (3) to create a for profit business that would generate revenue for its founder while he pursued his social work degree at a local university; and
- (4) raise the esteem of its residents and teach them the value of working together and supporting each other in their pursuit of long-term recovery; building a community that they each could be proud of and leaving a legacy that people do recover from addiction and make positive contributions to their environment and communities.

This final goal was the most important component of the Ujima Recovery Project.

Ujima was developed in 1996, in Pontiac, Michigan, a town notorious for its high rate of drug and alcohol abuse, as well as General Motors (GM) plants and assembly line workers. Ujima was a for-profit program that followed a simple fee for service business model. It was housed in a 16-room boarding house on the eastside of Pontiac that was leased by the founder for \$1,400.00 per month. Program participants, men and women in recovery who were also GM employees, leased rooms in the boarding house for \$75.00 per week. The house had 4 shared bathrooms and a common eating/kitchen area. Participants were responsible for preparing their own meals. The rules of program stated that if a resident relapsed (returned to drug or alcohol use) they would check into a local homeless shelter for 3 nights before they could return to the program, provided they could produce a drug free urine sample. Another rule stated that residents could not have overnight guests, but were allowed weekend passes after their first 30 days in the program. The final rule stated that participants would adhere to a weekday curfew of

10:00 pm and a weekend (Friday and Saturday) curfew of 1:00 am. As this idea grew, the demand for addiction recovery transitional housing programs that were supportive and culturally appropriate also grew; not just locally, but throughout the United States. It was clear to Ujima's founder that to be truly successful the program would need to refocus its mission and replicate itself in a much larger city with a much larger African American population. The challenge at this stage was to "plan and prepare" for a shift from a limited idea to a clear vision of an organization that would mobilize supporters from the addiction recovery community and move the concept to the next level of implementation. It was imperative that words, dreams, and thoughts be translated into a concrete plan of action. Success of this new and expanded vision hinged upon a combination of insight from the founder's personal recovery, passion, business acumen, and knowledge and skill obtained through his social work education and training.

From Conception to Birth – Recovery Consultants of Atlanta, Inc.

Smith, Buklin and Associates, Inc. (2000) suggest that transforming an organization into a well-planned, well-managed, high functioning, responsive nonprofit, there must be a clearly defined mission, strong organizational infrastructure and most importantly, there must be a shift from an individualistic leadership style of the founder to an expanded consensus type of leadership. To err at this stage in the development of a nonprofit organization is to fall victim to the "Founder's Syndrome" (Smith, Buklin and Associates, Inc., 2000) which is characteristic of the early stages of an organization's development. In general, the founder's syndrome inhibits growth and expansion when the founder or group of founders' personal passion and charisma that use to be the driving force for the organization is no longer sufficient to push the organization forward in achieving its intended mission. To avoid the pitfalls of this syndrome, Grobman (2005) state that it is important to leverage the founder's strengths and vision to create

the new entity that is capable of sustaining the vision for the organization that is more in sync with the needs of the target community. RCA, Inc.'s founding member was an individual in addiction recovery who had earned a masters degree in social work as a result of his recovery. He was not only an experienced addiction professional but also a compassionate and committed Christian. He would ultimately learn to combine his experience, education, and faith and become a mentor and role model for program participants as well as others in addiction recovery, not just locally, but throughout America.

RCA, Inc. was born out of the need to create a sustainable organization that would provide culturally-based addiction recovery support services to homeless substance users, most of who would be African American. Notions of cultural competence moved beyond ethnic/racial matching to include the culture of addiction recovery. Services developed by RCA, Inc. would be provided by African American men and women in addiction recovery. RCA would use the "hip-hop" acronym "FUBU," For Us by Us, as its theme.

RCA, Inc.'s founding member began constructing the blueprint for the agency in 1999, within 6 months of graduating from the University Michigan with a Masters degree in social work. His first employment position as an MSW was as Project Coordinator for the Southeast Addiction Technology Transfer Center (SATTC). The SATTC is located within the Morehouse School of Medicine (MSM) and is part of a nationwide network of addiction technology transfer centers funded by CSAT/SAMHSA. The SATTC has as its primary function, the dissemination of addiction treatment information to frontline addiction professionals. In addition, it is charged with promoting science to service treatment approaches that support workforce development and practice improvement. This means they are responsible for training frontline addiction professionals in evidence-based treatment methods, leading to an enhanced group of treatment

professionals. They sponsor and co-sponsor training events; address special needs of specific populations to support cultural competency; and provide technical assistance to the addiction treatment community. They also provide continuing education in addiction treatment to practicing professionals.

As project coordinator with the SATTC, he was responsible for traveling to historically Black colleges and universities (HBCUS's) in Georgia, Florida, Alabama, and South Carolina and informing graduating seniors and graduate students of the career opportunities in the addiction profession, including careers as counselors, administrators, and researchers. The CSAT agenda was to work through the SATTC to enhance the number of African American addiction professionals. This was in response to the significant number of retiring professionals in the field and to keep pace with the increasing number of African Americans seeking and in need of addiction treatment.

The SATTC experience became the impetus for RCA, Inc.'s founder to begin considering alternative options that would allow him to work directly with people in early recovery and with homeless substance users in need of recovery; replicating the Ujima program that he developed while in his early days pursuing his social work degree.

As such, in 1999, he began to mobilize a small group of individuals who had earned graduate degrees as a result of their personal recovery from addiction to be a part of the development of this new organization. This group consisted of an MSW who had graduated from Clark Atlanta's school of social work, a second MSW who was licensed as a clinical social worker, and a person with a Masters of Business Administration (MBA) degree, who held an undergraduate degree from Morehouse College. All three were individuals who identified as persons in long-term recovery. The founding member motivated each of them to join him in

establishing an organization that would improve the quality of life for people new to recovery and for people who were homeless and in need of recovery. This group of four became the original board members of this organization. They named the organization Recovery Consultants of Atlanta (RCA) because they considered themselves consultants to people in recovery. RCA would become an organization where substance users would learn to overcome their addiction, sustain their recovery, live life abundantly, and give back to their communities by helping others find recovery. This new program would be designed based on the personal experiences of these founding members: experiences as active drug users combined with their experiences as persons in long-term addiction recovery. The program would motivate people in recovery to consider pursuing formal degrees including General Equivalency Diplomas (GED) as well as associate, undergraduate, and graduate level degrees, as a method for enhancing their recovery and career opportunities.

Establishing RCA as a Georgia Nonprofit

Within nine months of the initial planning, RCA was incorporated as a non-profit with the state of Georgia and the official name of this entity was established as Recovery Consultants of Atlanta, Incorporated (RCA, Inc.). Nonprofit organizations such as RCA are not automatically granted nonprofit tax exempt status. This is a designation granted under section 501(c) 3 of the Internal Revenue Code. In order to pursue Federal, state, and other government funding, an organization is required to have this designation. Following are the procedures RCA, Inc. pursued for establishing a nonprofit corporation in the State of Georgia.

Step-By-Step Process

In July 1999, RCA was incorporated as a non profit entity with the state of Georgia. This required the paying of a non refundable \$60.00 fee. During this same month, the name Recovery

Consultants of Atlanta, Inc. was advertised for 2 weeks in the Champion Newspaper to determine if the name was currently being used by any other agencies. This required the paying of a \$40.00 fee. Post the 2 week wait period, it was determined that this name was not being used anywhere else in Georgia. During this same period, an application form SS-4 for an Employer Identification Number (EIN) was filed with the Department of the Treasury Internal Revenue Service. And finally, because RCA had no permanent address or office, a Post Office Box address was established as the place where the organization would receive correspondence. This required a \$32.00 fee. Reserving the name of the organization led to RCA, Inc. receiving its EIN. The next step in the process was to prepare the articles of incorporation.

The EIN was placed on the required *Transmittal Form 227* that was filed along with the articles of incorporation, with the state of Georgia. There were 6 articles filed. Article 1 established RCA, Inc's name; article 2 documented RCA, Inc. as a non-profit according to the Georgia Nonprofit Corporation code; article 3 recorded the physical address of the corporation; article 4 recorded the name of each board member; article 5 indicated that RCA, Inc. would not be established as a membership organization; and article 6 recorded RCA, Inc's mailing address. These articles were notarized and filed with the Corporations Division at 315 West Tower, #2 Martin Luther King, Jr. Drive Atlanta, Georgia 30334 with the required \$100.00 filing fee.

In August 1999, RCA, Inc. obtained an official EIN from the IRS which was required prior to submitting the completed 501(c) 3 application. In February 2000, RCA, Inc. submitted an application to the Internal Revenue Services to become a tax exempt 501 (c) 3 organization. This action required the paying of a non refundable \$500.00 fee. In June 2000, RCA, Inc. received a conditional 501 (c) 3 status from the IRS. The official mission of RCA, Inc. was established to provide peer-based addiction recovery support services to members of inner-city

Atlanta's addiction recovery community; focusing specifically on homeless substance users in need of recovery. (See Appendixes B and C).

Disgruntled Board of Directors

Although the original board members had achieved significant accomplishments in a very short time, they were operating as an unfunded program; attempting to provide services without any money. Without funding, the board was becoming disgruntled and disillusioned. It is a very common theme for board members in the early process of establishing a nonprofit to become frustrated (Grobman, 2005). What started out as a wonderfully exciting opportunity was quickly becoming just another good idea that was not materializing. Motivating the board members into believing that a mere vision could be transformed into an institution with national recognition was a constant barrier. The board members constantly referred to the founding member as a dreamer. Dym & Hutson (2005) note that this is typical in the developmental stage of a nonprofit organization. Thus, the role of RCA, Inc.'s founder was to continue to dream and stir up passion in the remaining board members until they too could come to believe in the dream. But this was not working and the initial board members began to slowly dissociate themselves from the organization. As board members resigned, replacements would be recruited only to have them disappear almost as quickly as they joined. During this difficult time, the founding member continued keeping the organization afloat by holding board meetings at his home, taking responsibility for all administrative tasks, and focusing on locating potential funding sources.

Allies and Partners in the Developmental Stage

Having allies, partners, and/or mentors is a concrete way to provide support to the founder/founders of a new nonprofit (Smith, et. al., 2000). RCA, Inc. had no allies, partners, nor mentors during their developmental stage. In addition to not having allies they had only one

strong board member to lead the vision. However, this lack of support was not enough to deter the founding member from striving to make RCA, Inc. into a unique, cutting edge, culturally relevant, consumer driven addiction recovery support program. He would often report that he believed it was his strong belief in God that served as the source that sustained RCA, Inc. through these difficult times.

During the time of RCA, Inc.'s inception, the majority of the substance use treatment programs in the immediate area were based on traditional treatment models, utilizing mostly credentialed staff as providers of addiction services. RCA, Inc. on the other hand was striving to carve its own niche in the treatment/recovery field utilizing a unique paradigm shift, one that would resonate through Atlanta's recovery community like no program before it. This program would be founded by people in recovery and would enhance the quality of life for a large number of Atlanta-based homeless substance users. This approach was radically different from the treatment model of the day and this uniqueness contributed to the lack of mentors and allies RCA, Inc. had for support or direction.

From Vision to Strategic Plan

RCA, Inc. had graduated beyond the questions of what and when, to the salient question of how to become a legitimate entity capable of realizing its potential. The challenge at this point was to move ideas into action. Its primary founder worked tirelessly trying to obtain a consensus from whatever board members were serving at the time to formulate a solid plan and strategy for staying focus and moving forward. To assist in this process, he led the board through a Strengths, Weakness, Opportunities and Threats (SWOT) analysis. Famed business and management consultant Albert Humphrey pioneered the SWOT analysis (Koo & Koo, 2007), which is a tool

used for organizational planning. In general, a SWOT analysis involves an assessment of an organization's *strengths, weaknesses, opportunities, and threats*.

Table 5.1 captures the SWOT assessment of RCA, Inc. It identified the organization's strengths or positive qualities that could be leveraged, weaknesses that needed to be remedied, opportunities or potential for success, and threats. These are all the components necessary for ensuring and preserving the growth of an organization (Koo & Koo, 2007).

Table 5.1

SWOT Analysis for RCA, Inc.

<p>STRENGTHS</p> <ul style="list-style-type: none"> • Strong vision/mission • Legal entity • Located near target population • Credentialed board members • Addressing a community need • Consumer operated • Culturally competent • Expertise in substance use recovery • Prior experience working with target population • Knowledge of substance use technology transfer and service delivery • Minority operated non-profit • Committed founder 	<p>WEAKNESSES</p> <ul style="list-style-type: none"> • Novice corporation • Lack of demonstrated organizational capability • No funds or funded programs • No paid staff • No partners/mentors • No formal training in nonprofit planning • Unstable board of directors • Lack of formal training in operating a nonprofit
<p>OPPORTUNITIES</p> <ul style="list-style-type: none"> • New policies that support consumer operated services • Potential for competing for federal funds • Mobilization of professionals in recovery • Make a significant difference in the lives of those in recovery 	<p>THREATS</p> <ul style="list-style-type: none"> • Founder's syndrome • Lack of trust among board members • Competition • Board apathy and selfishness

Once this initial stage of planning was completed, it was clear that the organization possessed more strengths than weaknesses and had more opportunities than threats to its success. The strengths were embodied in the vision and mission of the organization. This would be a culturally competent addiction recovery support program that recognized the strengths of the recovery community to care for its constituents. The opportunities were many. There was a new focus by SAMSHA to fund consumer operated Recovery Community Organizations (Clay, 2004). Much of this new direction grew out of the advocacy of the mental health consumer movement occurring during the late 1990s (White, 2006). This consumer movement demanded that the power differential that existed between patient and provider be challenged and that patients be empowered to make their own health related choices (Tomes, 2006).

RCA, Inc. was positioned to be a beneficiary of the changing times with regards to expanding addiction recovery policies and funding opportunities for substance users. Undoubtedly, a lack of funding was a major weakness for RCA, Inc. This is typical of newly formed nonprofits; however, this threat was not significant enough to halt their forward movement. The organization depended upon volunteers who supported the vision and the tireless effort of its primary founder who strived daily to keep the organization afloat. The organization would have benefited from the expertise of similar and more established recovery community organizations, however, there were none known to this group during their infant stage. RCA, Inc. was a pioneer organization with a radical approach to addiction recovery. In order to survive, it had to stand on its own, capitalizing on its strengths and working to eliminate its weaknesses.

Threats to implementing a dream are always eminent whether real or imagined. One real threat for RCA, Inc. was a lack of motivation and apathy among its board members. The founding member spent much of his time attempting to motivate supporters and board members

to stay committed to the dream. Motivation is either intrinsic or extrinsic (Koo & Koo, 2007). Intrinsic motivation dictates that the rewards of helping to implement a dream are inherent to the task (Koo & Koo, 2007). In theory, supporters were there because they wanted to be part of what RCA, Inc. represented. Extrinsic motivations are rewards that are external to supporters (Koo & Koo, 2007). In the case of RCA, Inc., the primary extrinsic motivator was funding. The economy of that time (2001-2006) was stable but accessing funds was challenging. Individuals who were solicited for contributions made verbal commitments but no actual donations were received. There were limits of what volunteers could do to build the organization as well as limits to what the organization could realistically accomplish without funding.

At this stage, RCA, Inc. was again operating like a “one-man show.” The primary founding member was doing all the work: galvanizing support; marketing the dream; and trying to keep the dream alive. Founders are often in this position which makes it difficult to complete future tasks such as composing a board of directors who will keep the organization’s best interest in mind and who wholeheartedly support the founder (Dym & Hutson, 2005). It becomes increasingly difficult for this type of founder to hand over his/her “baby” to people who may not care for the “baby” in the way that the parent would (Dym & Hutson, 2005). Trust played an important role here. Notions of how could the founder trust those who only seemed interested in lending support provided the agency received major funding was a threat. Would these supporters remain when the attempts to raise funds failed or would they always be there in support of the mission?

Competing for government funding is a constant threat to any new nonprofit, especially a consumer operated nonprofit. More established organizations have years of experience and presence in a community as well as their reputation for success with clients. RCA, Inc. would

need a strong sales pitch to win contracts and draw clients to this newly established nonprofit. RCA, Inc. would also have to compete with other nonprofits for local, state, and federal funding for its programs.

Once the SWOT analysis was completed and the data was analyzed, RCA, Inc. was ready to move forward with planning. There are several types of planning strategies for new organizations. Given that none of the founders were experts in nonprofit planning, RCA, Inc. needed to utilize a strategy that would help it generate a list of priorities and articulate these priorities in terms of obtainable goals and measurable objectives. Planning also involved identifying the resources that would be needed to implement the goals, define roles and responsibilities, and lastly, agree upon dates for task completion.

Planning Approach

Although, there are several ways to approach planning with a new nonprofit, it is not uncommon for organizations to begin with a great vision but no plan of action (Grobman, 2005). RCA, Inc. is one of those organizations that had a great vision but no carefully crafted plan of action. Initially, they were organized to provide consultation to people in recovery who wanted to advance their level of education. However, this focus limited their potential and made it difficult if not impossible to address the multi-dimensional needs of people in recovery. Therefore, an organization plan was developed that would have the capacity to address the multiple needs of people in recovery as well as create an infrastructure leading to the development of programs that would address these needs. Because one of the identified weaknesses in their SWOT analysis was a lack of formal training in nonprofit planning, RCA, Inc. took an incremental approach to program planning and development and to guiding the direction of the organization. The founders had an in-depth knowledge of the needs of the target

population and were therefore able to outline initial goals, objectives, and expected outcomes for the organization. A timeline for goal attainment was generated and a proposed budget was crafted. The next step was to secure funding and obtain the necessary resources needed to achieve the stated goals.

Funding the Dream

According to Grobman (2005), total revenues and contributions for nonprofit corporations in 1998 totaled more than 664 billion dollars. Private contributions accounted for 37.5 percent, government funding accounted for 31.3 percent, and 11.4 percent was raised through investments.

The founding member's employment at the SATTC served as an introduction to CSAT. This introduction would ultimately segue into the world of federal grant writing for him. He was exposed to the inner workings of SAMHSA and CSAT and became knowledgeable about what they expected of organizations that submitted requests for federal funding. Most importantly, he was able to network with peers at the federal level who learned of his passion and were interested in his approach to providing peer-based recovery support services. As such, he was invited to numerous speaking engagements and award ceremonies. Therefore, it was only natural that the board of directors, under the founding member's leadership, would choose to submit RCA, Inc.'s first federal grant proposal to SAMHSA/CSAT. CSAT was extremely happy with RCA, Inc.'s focus on assisting homeless African American substance users and assisting those new in recovery with pursuing formal degrees. They were also proud of this founding member, a young African American man who had overcome a 13 year history of heroin addiction to earn a graduate degree in social work and develop a mission to operate a nonprofit organization designed to help others in recovery achieve similar dreams.

Initial Federal Funding

In the spring of 2000, CSAT posted a Request for Proposal (RFP) to fund 11 national nonprofits to mobilize individuals in recovery and develop an advocacy movement designed to teach them how to tell their story of recovery without violating the anonymity principle of their respective 12-step fellowship. An RFP is a competitive grant application that nonprofits respond to and compete for funding from a funding source; in this case, the Federal Center for Substance Abuse Treatment. This advocacy movement was designed to educate the general public on the truths about addiction and recovery and eliminate the stigma that addiction was a moral deficiency and that people who used or abused substances were bad people. This grant would become known as the Recovery Community Support Program (RCSP). RCA, Inc.'s founder completed and submitted this application on behalf of RCA, Inc. He did this in spite of the fact that he had no prior grant writing experience and while he was preparing to begin his Doctoral Studies at the University of Georgia's School of Social Work.

In September 2001, RCA, Inc. was notified by SAMHSA/CSAT that it had been chosen as one of eleven nonprofits to receive the RCSP grant award. The award was made in October 2001. This was RCA, Inc.'s first funding of any kind. The award was funded for five years from October 2001 to September 2006, at \$200,000.00 per year, for a total of 1 million dollars. This award charged RCA and ten additional RCOs, each strategically located throughout the United States, with the responsibility of leading one of our nation's most profound movements aimed at raising awareness around addiction and recovery while simultaneously reducing the stigma associated with both. See Appendices D (Notice of Grant Award), E (Letter from Senator Miller, F (Newspaper Article on Award), and G (Letter from UGA President).

Staffing the RCSP Grant

The fragmented board that existed during the time RCA, Inc. received its RCSP award from CSAT decided that the founding member would serve as the executive director in the grant and would continue to serve as the board chair until a replacement could be identified. When RCA, Inc. received the CSAT grant award they were completely shocked. The founding member was quoted as saying, “We were not expecting to get funded; we were only hoping that they would let us know what was strong and what was weak about our application so that we could make adjustments to our next SAMHSA grant application.”

The ED would spend the first 30 days of the grant searching out locations to open an office. The Greater Piney Grove Baptist Church, located in East Atlanta owned a house next to their church that they used infrequently for community meetings. The ED decided to inquire about the possibility of leasing the house to serve as the office of RCA, Inc. The church’s pastor, Reverend Doctor William Flippin thought that it would be an excellent idea to have RCA, Inc. located in this space. He met with key members of the church who then in turn met with RCA, Inc.’s ED and agreed on a month-to-month lease of \$500.00, for as long as RCA, Inc. wanted to lease the space.

For the first 3 months, the ED would serve as the sole employee of RCA, Inc. He spent this time engaging community residents, individuals in recovery, and faith-institutions soliciting their input into methods for recruiting individuals in recovery and strategies for educating them on how to become advocates of recovery without violating their anonymity/confidentiality. During the period January 2002 until September 2003, RCA, Inc. trained more than 50 members from Atlanta’s recovery community on how to become effective spokespersons for recovery and

how to interact with legislators and encourage them to support programs that resulted in more addiction treatment and recovery options for the poor and underserved.

In August 2002, a well experienced young woman with a Bachelor's Degree in Social Work (BSW) would become the associate director (AD) of RCA, Inc. She would join the ED and the two of them would lead the trainings and recruitment of members from the recovery community. The AD would have an added responsibility of engaging key persons at local Atlanta-based churches and encouraging them to allow us use of their facilities as training sites. This action would result in the beginning of our faith-based movement.

Beginnings of RCA, Inc.'s Faith-based Movement

Between October 2002 and September 2006, RCA would expand its efforts and begin to focus on providing P-BRSS, through a spiritual collaboration with a core group of inner-city Atlanta churches. Together they would develop a "faith-based coalition" and began implementing a plethora of church defined social support services and RCSP defined peer-based addiction recovery support services. These services were designed to help men and women seeking recovery from alcohol and/or drug addiction begin and sustain their recovery. These combined experiences would serve as the foundation of a historical moment in Atlanta's addiction recovery culture – one that would raise awareness, reduce stigma, encompass Christian pathways to recovery, and bring to rest the ignorance surrounding addiction and recovery.

Though the 2001 RCSP cohort functioned as a national network, they also operated independent of one another with full autonomy and the right to choose its own target group (as long as the group included substance users seeking or in need of addiction recovery) as well as the right to develop its own P-BRSS. For example, an RCSP grantee in Tucson, Arizona focused its efforts on undocumented Latinos and Latinas in need of addiction recovery, while a group in

New York City focused its efforts on Lesbian, Bi-sexual, Gay, and Transgender substance users. This important privilege allowed RCA to choose as its target group homeless African Americans in need of addiction recovery. This target group was selected based on the following realities:

- (a) Atlanta's African American population trailed only New York, Detroit, and D.C. as the largest in America (US Census, 2005);
- (b) Atlanta's homeless population of approximately 16,000 people included more than 87 percent who were African American and more than 47 percent who were homeless as a result of drug and alcohol dependence (Tri-J Survey, 2007);
- (c) Drug use could be directly correlated with HIV, viral hepatitis, and tuberculosis among homeless African Americans (NIDA, 2002);
- (d) Effective interventions focusing on reducing drug use and its related ailments among African Americans were most successful when facilitated by African Americans (White 2009; Schiele, 2000; Longshore et al, 1998); and
- (e) The Black Church is the leading provider of social support services in the African American community (Brown, 2003).

These facts served as the underpinning for the development of a peer-based faith-based RCO. During the 5 year period of this study, RCA would gain a reputation for being one of America's leading providers of P-BRSS and would be honored by the Bush II Administration as a leader among community-based organizations receiving faith-based funding from the federal government.

Of the 11 RCSP funded by CSAT in 2001, RCA, Inc. was the only one refunded in October 2006. The total amount received for this second award was \$350,000.00 per year, for 4 years; a total of 1.4 million dollars.

Grant's Focus

It was important that RCA, Inc. pursued funding opportunities that were directly aligned with the vision and mission of the organization. The RCSP award charged RCA, Inc. with the responsibility of implementing an array of peer-based recovery support services for its target population. This grant's mandate fit perfectly within the framework of RCA, Inc.'s mission. The grant made it possible to fund all the services RCA, Inc. had envisioned for its constituents. In addition, reaching successful outcomes would put RCA, Inc. in line for additional CSAT funding. Table 5.2 describes the "core" services and activities that were offered by RCA, Inc. with the RCSP grant. These were standing services that were offered throughout the life of the grant. Following this core group of services is a list of "specialty" services offered during the period.

Table 5.2

Peer-based Recovery Support Services Provided with RCSP funds from 2001-2006

Service	Activities
Peer-based outreach	This service linked homeless substance users with publicly funded detox, drug treatment, and subsequent recovery support services. Facilitated by paid outreach workers.
Center for Excellence on Peer-based Recovery Support	This service provided more than 30 weekly 12-step, faith-based, health specific (HIV and Hepatitis C), gender specific, family specific, and co-occurring support groups. Narcotics Anonymous, the preferred 12-step program for low income substance users (Kingree, 2001) was the group offered most often at the center. Center was operated by paid staff and volunteers.
Intensive case monitoring	This service provided weekly phone and/or face-to-face dialogue with clients and monitored their participation in peer-led recovery support services. This service was facilitated by volunteers.
Peer-based transitional housing	This program provided housing for men and women in early recovery and was modeled after the Ujima recovery housing program.

Table 5.2 Continued

Service	Activities
Recovery at Work (RAW)	A social entrepreneurial program developed in partnership with a faith-based partner. RAW offered full and part-time employment to clients in RCA, Inc.'s treatment and/or transitional housing program (residential and commercial painting, pressure washing, roofing, and lawn care). This program employed between 10 - 12 clients at a time.
The SAVED SISTA Project	This is a faith-based, peer-led, substance use, HIV and intimate partner violence prevention program for homeless substance using women. This 6-week program occurred 6 times per year. Each session was for a different group of 6-8 women. The sessions rotated among RCA, Inc.'s faith-based coalition members. This project was based on the CDC's evidenced-based HIV prevention practice, SISTAS Informing SISTAS about HIV and AIDS. This practice was modified to include a substance use and intimate partner violence prevention component. Each session was facilitated by female recovery coach from among RCA, Inc.'s core group of volunteers.
Transportation and Childcare	This service was provided to single mothers who attended the weekly faith-based support group Celebrate Recovery. This recovery support service addressed the 2 barriers that made it most difficult for single mothers to participate in recovery – lack of childcare and lack of transportation.
Better Parents = Better Kids	This 10-week program occurred 2 times per year and was offered in partnership with one of RCA, Inc.'s faith-based partners. This program enhanced the parenting skills of 20 single parents in recovery (10 per group), helping to improve the overall relationship between group participants and their children. While parents participated in weekly sessions, their children participated in simultaneous prevention education sessions designed to teach them how to avoid behaviors and environments that could possibly lead to becoming involved in illicit substance use. Both groups were facilitated by RCA, Inc. volunteers.
Workforce Development Initiative	RCA, Inc. offered a Certified Addiction Counseling (CAC) training program, in partnership with the Southeast Addiction Technology Transfer Center, located at Morehouse School of Medicine. This program provided educational hours, clinical supervision, and internship opportunities for individuals in addiction recovery, with a minimum of 2 years sobriety, who were interested in becoming addiction professionals. More than 150 persons in recovery have participated in this service.

Special Faith-Based Events Sponsored by RCSP Grant

Once RCA, Inc. received its faith-based designation from CSAT, it immediately began to offer services in partnership with Atlanta-based churches, including an annual “Christians In

Recovery from Substance Abuse Conference (CIR)” focusing on both faith-based (specifically Christian-based) and 12-step approaches to addiction recovery. Providing an annual conference for providers and recipients of addiction services from a religious perspective was challenging, particularly when the conference was being sponsored with federal funds. There is a clear prohibition against using federal funds to promote religious events (Brown, 2003). However, RCA, Inc. was successful at hosting an event with federal funds that clearly “highlighted the value of seeking religious involvement” as a strategy for developing recovery programs that help sustain recovery among homeless substance users. This event was not intended to convert participants to Christianity, though the Christian influence of this event was clearly apparent.

The CIR conference was a major success. More than 250 individuals attended. Participants came from as far away as South Carolina, Alabama, and Ohio. The conference served as a catalyst for subsequent conferences, not only in Atlanta, but in other parts of the country. Within one year replicates of this conference were taking place in Detroit, Syracuse, Miami, and Cleveland. Because this conference came on the heels of the Bush Administration’s push to include faith institutions in the receiving of federal funds, it was not surprising to see conferences of this nature popping up across the country. Appendix H provides a description of the announcement for Christians in Recovery II. This was the first year that CSAT/SAMHSA required RCA, Inc. to include a “disclaimer” in their announcement informing participants and others that the “views and opinions” of the conference leaders and participants did not necessarily reflect the views of SAMHSA or CSAT. This conference keynote speaker was Mr. Charles Currie. At the time, Mr. Currie was the administrator of SAMHA, having been appointed to this position by George W. Bush. Mr. Currie is now a board member of the Council on Social Work Education (CSWE). This conference was also co-sponsored by the University of Georgia’s

School of Social Work. This co-sponsorship added credibility to the conference. See Appendix H (Christians in Recovery Conference Announcement)).

Faith-Based Support Services

Christians in Recovery from Substance Use commenced a ripple effect throughout the Atlanta community thanks in part to President George W. Bush's Faith-based Initiative and push to include faith institutions in the group of eligible recipients of federal funding. African American support for President Bush's faith-based initiative was due largely in part to their overwhelming support for the 1996 "Charitable Choice" regulation that called for a "leveling of the playing field for faith institutions seeking federal funding" (Brown, 2003). Unfortunately, for many Black churches, the perception was that this meant that they could now become recipients of federal funding. What they were mistaken about was the fact that securing federal funds was a competitive process and many Black churches lacked the resources necessary (experience, grant writers, infrastructure) for competing for federal funds. Brown (2003) offers this insight:

In June 2001, he [Bush] held another faith-based summit with 500 religious leaders, most of which were black or Hispanic. However, just because black pastors have featured prominently in Bush's campaign to expand faith-based efforts in this country, it does not mean that a large sum of federal funds will be flowing to black churches. To be clear, Charitable Choice is not a pot of money reserved for faith-based social service efforts. It only allows religious organizations to take part in a competitive grant writing process where applicants must prove their ability to provide quality social service. (p. 79)

Collaboration with New Birth Missionary Baptist Church

RCA, Inc.'s faith-based status proved to be very important and beneficial. In the fall of 2003, they co-hosted a second faith-based conference for substance users and providers of

addiction services entitled, “Behind Enemy Lines: Mission Possible Faith-Based Conference.” What was most significant about this event is that it was held in partnership with New Birth Missionary Baptist Church, one of America’s largest Black churches. New Birth is led by Bishop Eddie Long, a prominent African American minister. Bishop Long had been one of the African American ministers invited by Bush to the White House. He was also a very outspoken supporter of President George W. Bush during his initial campaign. Prior to this partnership, RCA, Inc.’s faith-based partners consisted of small to medium size inner-city Black churches (Whiters et al., 2007). This new partnership highlighted RCA, Inc.’s influence that came as a result of their faith-based designation.

The Behind Enemy Lines conference featured members of Atlanta’s recovery community as speakers and workshop facilitators. The attendees response to the conference was encouraging and supportive and further evidence of RCA, Inc.’s ability to attract significant numbers of recovery community members who were either Christian or open to Christian-based interventions. When the leaders at New Birth sought RCA, Inc.’s partnership they did so believing that this would result in a high turnout for their conference. As a result of RCA, Inc.’s involvement the conference attracted more than 250 participants; twice the number of people expected. RCA, Inc. not only took the lead in marketing this event, but also assured participants that this program would not be a duplication of their “Christians in Recovery from Substance Use” conference; hosted earlier that year in April. RCA, Inc.’s staff worked diligently to develop workshops that their supporters would find useful for both their personal recovery and professional careers.

This conference offered an array of breakout sessions that highlighted some very effective and easy to replicate peer-based services. The conference workshops focused on the

best practices for treating victims of domestic violence, methods for addressing substance abuse within families, the role of the legal system in addressing substance abuse issues, and workshops educating both clergy and faith leaders on how to better prepare themselves to deal with addiction. This conference also included a plenary session on homophobia. This attempt to encourage Christians to be open-minded and culturally sensitive when addressing substance users or church members who identify as lesbian, gay, bi-sexual or transgender (LGBT) did not go over well with many of the conference participants.

Homophobia is a fear of or prejudice towards individuals who identify as LGBT. Because homosexuality is considered a sin among many within the Christian and other faith communities, RCA, Inc.'s attempt to move participants past this obvious point of prejudice to a more civilized attitude of acceptance failed. This was determined based on the overwhelming number of comments categorizing homosexual as a sin and homosexuals as sinners. One very disturbing comment made by a participant who identified himself as a "Christian in Recovery," was that "God did not want him to hate the sinner but he did want him to hate the sin . . . and homosexuality is a sin."

Homophobia is not limited to faith communities. Even within the Afrocentric belief system there is an abundance of homophobia. Leading African American scholar Molefi Kete Asante (1988), in his famous book *Afrocentricity*, states that "homosexuality is a deviation from Afrocentric thought because it makes the person evaluate his own physical needs above the teachings of national consciousness" (p.57). There is no evidence to support this statement. To suggest that a person who is LGBT would automatically place their sexuality above their ethnicity is a stretch. What about black women who place their gender above their ethnicity? Is this too a deviation from the Afrocentric perspective? In the world of peer-based recovery

support services gender, sexuality, and ethnicity are treated as “special populations.” This is why RCA, Inc. developed support groups specific to each of these populations. This recognition is based on the number of years these groups have been subject to discrimination and prejudice and the fact that many are more successful at finding and sustaining their recovery when they are allowed to recovery among one another – where they are able to speak freely about their experiences with racism, sexism, and other prejudices, such as homophobia. This was the point that RCA, Inc. attempted to highlight during its plenary session at the Behind Enemy Lines faith-based conference. However, this point fell on death ears, as many among this group refused to accept this logic. A very important point to highlight here is the fact that RCA, Inc. identifies as a “faith-based program” that supports Christian-based as well as non religious based approaches to recovery, while simultaneously supporting and being open to homosexuality and culturally appropriate approaches to recovery for individuals who identify as LGBT. This, in and of itself, warrants major praise and accolades.

Atlanta Coalition of Faith-Based Providers

As a strategy for developing a sustainable program, RCA, Inc. and several of its church partners instituted an Atlanta-based coalition aimed at enhancing the number of peer-based addiction recovery support services provided by faith institutions. The coalition concept would educate churches on how to provide similar if not the same services provided by RCA, Inc. as a strategy for ensuring that a multitude of services would be available for an extremely large number of homeless substance users in need of help.

Collaborating with inner-city Black churches was a “no brainer” for RCA, Inc. History has demonstrated that the institution providing the most support of any kind for poor black

people is the Black church (Brown, 2003). As it relates to the Black church's role in providing social support services, Authors Taylor, Chatters & Levin (2004) offer this insight:

Analysis of several surveys indicates that many black Americans are actively involved in church support networks. Findings from the Three Generation Family Study indicate that approximately six out of ten respondents receive help from churches. Respondents in the Grandchild Generation were more likely to receive help (and to receive help on a frequent basis) than were those in the Grandparent Generation. Members of the Grandparent generation were more likely to ask for financial assistance, help when sick, and transportation. Individuals in the Child Generation were more likely to receive socioemotional assistance in the form of advice, encouragement, and babysitting. (p. 166)

The initial coalition meeting took place in January 2003 in Decatur, GA, at the site of the Piney Grove Baptist Church. This meeting was attended by 31 metro-Atlanta churches. RCA, Inc. provided its expertise by facilitating a session on how to effectively build a coalition that would benefit metro-Atlanta faith and community based programs and providers. This coalition meeting was the first of its kind held in Atlanta aimed specifically at partnering with a federally-funded community-based organization for the purpose of developing a wide range of services specific to homeless substance users. Because federal funds come with clearly defined restrictions prohibiting proselytization (attempting to convert someone to a particular religious belief), only 6 of the original 31 churches agreed to be a part of the coalition. The majority of the church representatives were unable to accept the federal prohibition against proselytizing, or attempting to convert individuals to Christianity during any of the joint events held between the churches and RCA, Inc. It was also determined that many of the church representatives wanted to participate in the coalition because they saw this as an opportunity to access federal funds.

President Bush's "faith-based initiative" was buzzing throughout America's Black Church community. Though assisting Atlanta-based Black churches with assessing federal funds would become a later goal for RCA, Inc., this was not the goal of this initial meeting. The initial goal of this meeting was to form a strong collaborative among inner-city Atlanta churches and leverage federal funds in a manner that would expand services and remain in line with federal guidelines. In other words, use the funds that RCA, Inc. had received in partnership with churches to expand services to homeless drug users.

Each of the 6 remaining collaborative faith-based partners represented churches with large (1,000 – 1,600) to medium (300 – 600) size congregations (Whiters et al., 2010). They were each made aware of the prohibition against using federal funds to convert participants to any particular faith, and they each accepted this condition. This coalition was labeled "a group of open-minded churches" because of their willingness to partner with RCA, Inc. in a way that would not violate the federal prohibition against using federal monies for religious purposes. This coalition would ultimately serve as the catalyst to a wonderful host of services aimed at reducing drug use and homelessness among Atlanta-based substance users.

Recovery Month

National Alcohol and Drug Addiction Recovery Month (hereinafter referred to as Recovery Month) is an annual observance, sponsored by SAMHSA, which takes place during the month of September. In 2009, Recovery Month celebrated its 20th year (SAMSHA News, 2009). This national observance highlights how society benefits from addiction treatment, praises the contributions of treatment/recovery providers and promotes the message that recovery from substance use in all forms is possible. An example of the types of accomplishments that are

recognized during this month can be found in the following article located in the July 1, 2009 edition of the Baltimore Sun:

Deaths from alcohol and drug overdoses declined for the second straight year in Baltimore and are at their lowest level since 1995, when the city began recording the data, according to a Health Department report released today [July 1, 2009]. In 2008, 176 people died of a drug overdose in Baltimore, compared with 281 in 2007, a decrease of about one-third. Baltimore health officials called the figures significant and noted that they come at a time when overdose rates in other cities are climbing. They said increased treatment slots, better outreach to addicts and a five-year-old program that teaches drug abusers how to avoid overdosing themselves have contributed to the decline.

Each September a new theme or emphasis is selected for the observance. Recovery Month provides a platform to celebrate people in recovery and those who serve them. Each year, thousands of addiction treatment, recovery programs, and individuals in recovery from around the country celebrate their successes and share them with their neighbors, friends, and colleagues in an effort to educate the public about recovery, how it works, for whom, and why. Recovery Community Organizations such as RCA, Inc. have made significant accomplishments that are highlighted annually during Recovery Month. For RCA, Inc. these accomplishments include having transformed the lives of hundreds of homeless substance users, establishing a very successful faith-based coalition, and assisting hundreds of person in recovery enhance their levels of education. Successes of this nature often go unnoticed by the broader population; however, Recovery Month provides a vehicle to celebrate these successes.

Recovery Month also serves to educate the public on substance use as a national health crisis, that addiction is a treatable disease, and that recovery is possible. Recovery Month

highlights the benefits of treatment not only for the substance user, but also for their family and friends. Educating the public reduces the stigma associated with addiction, treatment, and recovery. Accurate knowledge of addiction as a disease helps people to understand the importance of supporting treatment/recovery programs. Recovery Month also encourages citizens to take action to help expand and improve the availability of effective substance use treatment for those in need. This goal is accomplished through letter writing campaigns to legislators and policy makers.

RCA, Inc.'s Participation in Recovery Month

In September 2002, RCA, Inc. began its participation in the annual observance of National Alcohol and Drug Addiction Recovery Month by painting 2 recovery month murals (the recovery wall) displaying the September 2002 Recovery Month theme "Join the Voices for Recovery: Celebrating Health" (see Appendix I, Recovery Month Mural).

RCA, Inc. utilized the mural to promote recovery from addiction throughout the metro-Atlanta area. The process for completing the mural was far more challenging than anyone at RCA, Inc. could have imagined. The idea for the wall was birth out of RCA, Inc.'s Recovery @ Work (RAW) program. The coordinator of this program, Mr. James "Jimi" Allen, initiated the idea for the mural. RAW is RCA, Inc.'s social entrepreneurial program that provides employment opportunities to men residing in their peer-based transitional housing program.

Mr. Allen thought that painting a mural on the depilated wall on an abandoned building located on the southeast corner of Candler Road would be a wonderful way of promoting recovery and RAW. The southeast corner of Candler Road is in Decatur, GA and the southwest corner of Candler Road is in Atlanta, GA. Candler Road is the dividing point between Atlanta and Decatur. This community is known for its drug using and drug dealing activities. The mural

Mr. Allen would say, “Would promote RAW, Recovery Month, and hopefully attract substance users to recovery.” The wall where RCA, Inc. wanted to paint the mural already had the remnants of an old worn out mural painted by the Columbia Cluster of the Atlanta Project (TAP), in 1993. TAP is a program that was founded in October 1991 by former President Jimmy Carter. Its purpose was to address the growing disparity between affluent and impoverished communities of Atlanta. Under the auspices of the Carter Presidential Library, TAP was to be a five-year effort, ending at the beginning of the 1996 summer Olympics that would confront the issues of urban poverty. Carter envisioned a collaborative, community-centered effort. This vision is captured in the mission statement of TAP:

The mission of TAP is to unite Atlanta as a community and work to improve the quality of life in our neighborhoods. In the spirit of the Carter Center's problem-solving philosophy, TAP will seek to empower citizens to develop solutions to the problems they identify in their neighborhoods and will foster collaboration among government agencies, other service providers, people who want to help, and those who need help throughout the area. We hope that The Atlanta Project can serve as a model and an inspiration for similar projects across America. The goals of TAP, drawn from this mission statement, are as follows:

- (1) To Unite Atlanta as a Community
- (2) To Foster Collaboration among Service Providers and Other Groups
- (3) To Enhance the Quality of Life in Atlanta-area Communities
- (4) To Foster Empowerment (retrieved from www.cpn.org on October 12, 2009).

RCA, Inc. learned that the building was owned by the DeKalb County Sheriffs Department, and though it appeared abandoned and closed from the outside, it served as storage space on the inside (see Appendices J and K). However, because RCA, Inc.'s mural would go on the outside wall, and because they were promoting a wonderful event, they approached the Sheriffs Department with full confidence that their request to paint a new mural over the old one would be a resounding yes. But such was not the case, and RAW experienced up close and for the first time stigma in its ugliest form. After several unanswered requests to paint the mural, it became clear to the men of RAW that the Sheriffs Department wanted nothing to do with anything related to drugs, even if it was an attempt to promote recovery. RCA, Inc. then decided to put into practice their advocacy training and contacted the DeKalb County Commissioners Office for support. When the Commissioners' office got involved the Sheriffs Department finally responded with a yes to RCA, Inc.'s request. However, the Sheriffs Department had a stipulation. They required RAW to paint over the mural with white paint at the end of Recovery Month. RAW and RCA, Inc. agreed, but not without being disappointed in this condition.

The men in the RAW program played a key role in preparing the mural by tearing down the old wall and rebuilding a new one. This allowed the airbrush artist to complete his work. The airbrush artist was a member of Atlanta's 12-step recovery community who was eager to come up with the concept for the mural as well as complete the mural in its entirety. This was a perfect example of the types of resources that were available to RCA, Inc. from within the Atlanta recovery community.

The men of RAW were thrilled to be a part of this project and to have one of the walls dedicated to their program. The Candler Road community showed great enthusiasm as they

watched the mural come to life. The mural resulted in several calls from individuals seeking recovery for themselves and/or for family members.

At the end of Recovery Month, RAW was preparing to paint a plain white wall over the mural in keeping with the condition placed on them by the Sheriffs Department. However, because the Candler Street residents viewed the mural as positive influence on their community, the Sheriffs' office changed its mind and asked RCA, Inc. to allow the mural to stand indefinitely. This is a perfect example of "stigma busting" and evidence of the effectiveness peer-based support services have on improving not only individual lives but also communities.

As a fundraising strategy, RCA, Inc. allowed members of the recovery community to sign their name or the name of deceased members from the recovery community and their clean or sobriety date on the wall in exchange for a donation (most donations were a dollar, though one donation was for \$500.00). The name signing event was received in such a positive way that it has led to an annual fundraising event for RCA, Inc. This entire effort demonstrated RCA, Inc.'s commitment to the recovery community and inspired others to give back to their respective communities (see Appendix L).

As a result of this accomplished task, recovery groups in Connecticut, Syracuse, New York City, and Detroit have posted murals of this nature in their communities. This is an example of how the peer-based recovery support services movement has a national impact, and how RCA, Inc. was able to design services that benefit individuals seeking recovery, not just in Atlanta, but across the nation.

Hosting the Eminent Expert on Peer-Based Recovery Support Services

In September 2003, in observance of Recovery Month, RCA, Inc. hosted the *Slaying the Dragon: The History of Addiction, Treatment and Recovery* workshop facilitated by William

“Bill” White. Bill White is the eminent expert on peer-based recovery support services and Recovery-Oriented Systems of Care. He has written extensively on both subjects and is recognized world wide as the leading expert on these interventions.

RCA, Inc. co-hosted this event with Ridgeview Institute, a privately owned addiction treatment provider in North Atlanta. This was significant for RCA, Inc. because this was the first event held outside of inner-city Atlanta borders and their first event held in partnership with a predominately white organization. The attendance to this workshop was overwhelming. It was standing room only and neither RCA, Inc. nor Ridgeview anticipated the turnout to be so large. The audience was significantly different from any of the previous audiences at RCA, Inc. events. For this event, the audience was about 50 percent White (all of RCA, Inc.’s prior events included mostly African Americans) and almost all were well-degreed professionals. What was similar to previous RCA, Inc. events was the fact that the majority were individuals who identified as persons in long-term addiction recovery.

Both RCA, Inc. and Ridgeview began to experience some anxiety when it was revealed that the number of pre-registrations exceeded the meeting room capacity. Ridgeview quickly responded by moving the event to a larger room, but this was still not enough to hold all of those who registered.

Sharing this diverse crowd of recovering folk with Bill White brought him a great deal of joy. He was extremely pleased and the audience absolutely loved his presentation. He did an excellent job of encouraging participants to become involved in RCA, Inc.’s peer-based recovery support movement. He also visited RCA, Inc.’s recovery month mural, took pictures, had them developed the same day, and now includes them in his presentations across the country. This

certainly brought joy to RCA, Inc. and is further evidence of the success of their movement (see Appendix M).

Support for Recovery Month Events Outside of Atlanta

In September 2003, in observance of Recovery Month, RCA, Inc.'s executive director traveled to Dallas and presented on their peer-based support group for individuals in recovery living with Hepatitis C. This recovery model had gained a reputation across the country as an intervention with major potential. It is reported that more than 4 million Americans, most of whom are active or former drug users and alcohol abusers, are living with Hepatitis C (Hep C Handbook, 2007). This is estimated at four times the number of Americans living with HIV (Hep C Handbook, 2007). Because RCA, Inc. was the CSAT funded RCSP serving a predominately African American population, it had taken the lead on developing peer-based support groups for substance users living with HIV and Hepatitis C. As a result, they received numerous invitations to travel to other cities sharing both their successes and challenges with the development and implementation of these support services. Based on the feedback RCA, Inc. received from Joe Powell, the Dallas' RCSP project officer, the presentation was well received. Still to this day, RCA, Inc. receives requests from across the country to present on their Hepatitis C support group. RCA, Inc.'s position on Hepatitis C is that it is to the addiction recovery community what HIV was to the substance using community 15 years ago. "We have had way too many of our "old timers" recovering from injection drug use with 15 – 20 years clean waking up with their livers depleted . . . at the very least we owe them education on the reality of this deadly disease and referrals for treatment" (David Whilters, RCSP Quarterly Report, January 2004).

Troup County Recovery Month Events

In September 2003, in observance of Recovery Month, RCA, Inc.'s Executive Director traveled to Troup County, Georgia (about 100 miles south of Atlanta) and helped members in recovery plan, organize, and implement several recovery month activities. These activities included a Walk-A-Thon, A Night of Prayer, a community event in the park, and a Run Drugs out of Town Campaign. The community response was very receptive to these activities and appreciative of RCA, Inc.'s contribution. RCA, Inc. was very effective at getting the faith community and 12-step community involved in these efforts. These efforts demonstrated RCA, Inc.'s ability to influence recovery events and mobilize support from both the 12-step and faith-based recovery communities.

Additional Funding from CSAT

In 1998, during the Clinton/Gore Administration, the Minority AIDS Bill was passed to increase funding to address HIV/AIDS in America's ethnic minority communities. This Bill recognized HIV as an epidemic among America's African and Latino communities. As a result, more than \$166 million was set aside by congress (in year 1) to address the HIV epidemic (Whiters et al., 2010). According to Aragon & Kates (2004):

The Minority AIDS Initiative (MAI) was created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. It provides new funding designed to strengthen organizational capacity and expand HIV related services in minority communities. Beginning with \$166 million in FY 1999, funding for the MAI has more than doubled since then, and is expected to total \$404 million in FY 2004. Although the MAI funds a number of critical direct services and has both political and symbolic significance, it represents less than 5% of federal

discretionary funding for HIV/AIDS in FY 2004 (\$8.7 billion). The MAI's principal goals are to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and reduce HIV related health disparities.

Central to these goals is the MAI's focus on efforts to strengthen the organizational capacity of community-based providers, in particular minority providers; improve the quality of HIV services; expand the pool of HIV service providers; and enhance the ability of minority service providers to compete for other HIV/AIDS funding in the future. Today, the MAI supports over 50 distinct programs targeting racial and ethnic minorities including the highest risk and hardest to serve populations. (p. 1)

In October 2003, RCA, Inc. was funded by CSAT as a faith-based Targeted Capacity Expansion for Substance Abuse Treatment and HIV/AIDS Services Program (TCE:HIV), under SAMHSA's Minority AIDS Initiative (MAI) project. RCA, Inc., as a strategy for expanding its peer-based recovery support services to homeless substance users living with and at risk for HIV infection, decided to pursue this announcement in hopes that they could raise additional funds and expand their services. RCA, Inc.'s executive director completed in its entirety this SAMHSA grant application and just like the first SAMHSA grant, he was pleasantly surprised when he learned that RCA, Inc. had been chosen among a group of 45 community based organizations across America as recipients of this grant award. As a result of this new funding, RCA, Inc. developed the Street Team for HIV/AIDS and Substance Use Risk Reduction (STARR) program. This program was designed to reduce substance use and HIV infection within Atlanta's homeless-drug using communities. This grant charged RCA, Inc. with the tasks of performing 100 HIV test per month for homeless substance users utilizing the OraQuick ADVANCE rapid test, while simultaneously linking a minimum of 16 homeless substance users per month with

publicly funded detoxification and subsequent drug treatment. This work became a significant strategy for reducing HIV infection rates among Atlanta's homeless drug using community. This is because science has shown that drug treatment is the most effective HIV prevention strategy for substance users (NIDA, 2002) and rapid testing is a successful intervention for reaching homeless drug users (Whiters et al., 2010; Collins et al., 2007).

The STARR program included four fulltime outreach workers; all of whom identified as persons in long term addiction recovery. They were each educated on the evidenced-based practice Motivational Interviewing and in the competencies of street outreach. RCA, Inc. took well trained volunteers from its RCSP grant and developed the STARR program and created these full-time employment opportunities for people in recovery. This is another example of everything that RCA, Inc. stands for – creating jobs while helping people in recovery and those who need recovery.

Their daily task included canvassing homeless communities of Atlanta and engaging homeless drug users and motivating them to a point where they (the homeless addicts) saw value in pursuing addiction recovery through detox and treatment. In addition, and at least one time each month, outreach workers would set up rapid HIV testing initiatives at homeless shelters and church sponsored soup kitchens, located throughout the metro-Atlanta area. The HIV testing initiatives would rotate among the member churches of RCA, Inc.'s faith-based coalition.

While blacks represent only 12 percent of the U.S. population (US census, 2009), they continue to be disproportionately affected by HIV/AIDS. At the close of the year 2006, there were an estimated 1 million, 100 thousand people living with HIV infection. Of this total, close to half (46 percent) were African American (CDC, 2009). This is evidence that the HIV/AIDS

epidemic among African Americans continues to be a major public health crisis throughout the United States and that there was a need for the STARR program.

Slight Modification to STARR

Within a few months of operation, the STARR program was a major hit within Atlanta's homeless community. This rapid success forced RCA, Inc. to modify its program slightly. This modification resulted in the recruiting, training, and using of volunteer counselors, mostly from within metro-Atlanta's faith community who would provide HIV and substance use prevention education to congregants within faith institutions using biblical principles. This initiative was very important and was designed to identify Christians who were also in recovery who might possibly be recruited as volunteer counselors with the STARR program. This strategy was based on the fact that many in the African American community present for help for drug and alcohol addiction at local churches. RCA, Inc. needed assistance from church members who understood that though prayer was important and beneficial when working with homeless drug users, having the skills to link them with appropriate detox and treatment programs was equally important. This modified approach encouraged church members to pray for potential clients but immediately after praying refer them to staff at RCA, Inc. The staff were responsible for linking clients with the "professional/secular" help they needed. RCA, Inc. believed that this type of partnership was important because they had begun to witness some Black churches play a "detrimental" role in helping substance users recover by giving many of them a false sense of hope by telling them that all they need was prayer and Jesus. For these reasons, RCA, Inc. knew they had to play an important role in educating the churches that were part of their coalition. RCA, Inc. developed a PowerPoint presentation that included language common among churches that encouraged them to continue their role as the prayer experts and to trust in RCA,

Inc. staff as the recovery experts. This training had become so popular that a RCA, Inc. volunteer provided this education to her church in Alabama where she was previously a member.

In September 2004, RCA, Inc. was designated by the Georgia Council on Substance Abuse (GCSA) as a Center for Excellence on Peer-based Recovery Support Services. This was a distinguished honor that truly recognized RCA, Inc. as a leader among community-based organizations providing addiction support services to homeless, Atlanta-based substance users. The GCSA is the state of Georgia's leading addiction treatment and prevention advocacy organization. GCSA's recognition of RCA, Inc. as a leader in the peer-based movement helped cement its place as a leader among addiction providers in the state of Georgia.

In September 2004, RCA, Inc.'s founder received the national "America Honors Recovery Award". This further cemented RCA, Inc.'s rightful place among our nation's leading providers of recovery support service. This award, the first of its kind, honored 8 Americans in addiction recovery from across the country as recipients (see Appendix N).

Of the more than 5 million Americans estimated to be in 12-step and faith-based recovery (NSDUH, 2009), RCA, Inc.'s founder was 1 of 8 selected for this distinguished award. This event was held on Thursday, September 23, 2004 and took place at the National Press Club Ballroom in downtown Washington, DC. This event was hosted by co-chairs Michael Deaver and a retired war hero and former US Senator Max Cleland. This award was a triumphant event in the history of RCA, Inc. and reflected on the awesome work and accomplishments made by this organization under the leadership of its founder.

Grant Expiration

In September 2006, RCA, Inc.'s RCSP grant came to closure – it expired. For 5 years, this grant made it possible for RCA, Inc. to provide services to more than 4,000 Atlanta-based

substance users. This project was extremely successful and its faith-based designation helped to place it among Atlanta's leading providers of services specific to homeless substance users. As a result of this grant and its faith-based coalition of Atlanta-based churches, RCA, Inc. became nationally known as a successful grantee of President Bush's Faith-based funding. RCA, Inc.'s bold approach to including faith-based and more specifically Christian-based approaches to addiction recovery in its implementation of services set it apart from all of the other CSAT funded RCSPs and further established it as a major leader and player in the recovery support movement. As a result, in October 2006, RCA, Inc. would be the only RCSP from the original eleven funded in October 2001 to be refunded by SAMHSA/CSAT. This was another example of the major accomplishments made by RCA, Inc. and the commitment made by SAMHSA/CSAT to refunding successful programs. Table 5.3 describes how each grant fit within the vision, mission and goal of RCA, Inc.

Table 5.3

Summary of Federal Grant Awards to RCA, Inc.

Year	Grant name	Purpose	Amount	Funding agency
2001-2002	Recovery Community Support Program	To lead a minimum of 150 individuals in recovery through an advocacy training program, developing spokespersons who would disseminate a message that addiction is an illness requiring treatment and not a moral deficiency or crime.	\$200,000.00 per year for 5 years. This program lasted only 1 year from October 2001 to September 2002.	SAMHSA/CSAT
2002 - 2006	Faith-based, peer-based Recovery Community Services Program.	To develop and provide peer-based addiction recovery support services to a minimum of 192 homeless substance users per year	October 2002 – September 2006	SAMHSA/CSAT
2003 - 2008	Substance Abuse Treatment and HIV/AIDS Services Program (TCE:HIV)	Performed 100 HIV test per month for homeless substance users utilizing the OraQuick ADVANCE rapid test, while simultaneously linking a minimum of 16 homeless substance users per month with publicly funded detoxification and subsequent drug treatment		SAMHSA/CSAT
2006	Recovery Community Services Program	Refunded to provide peer-based recovery support services		SAMHSA/CSAT

CHAPTER VI

Discussion & Conclusions

This historical qualitative study examined dozens of documents that were developed and created during a specific time period between June 1999 and September 2006, in Atlanta, Georgia. The documents were located in the archival files of RCA, Inc. This author spent several weeks examining documents stored in this archive that were specific to the research questions of this study. After examining all pertinent documents the following questions were addressed:

1. What was the motivation behind the development of Recovery Consultants of Atlanta, Inc.?
2. Who were the key players in the development of Recovery Consultants of Atlanta, Inc.?
3. What was the process for developing and institutionalizing this organization?
4. What were the initial and long-term goals of the organization?
5. How successful was the organization in meeting its goals and objectives?
6. What challenges if any were there related to the inclusion of Churches in the development and implementation of services?
7. What was the rationale behind the Afrocentric approach to addiction recovery?

Addiction Recovery among African Americans

Though RCA, Inc.'s decision to pursue a peer-based approach to addiction recovery for African Americans has been revolutionary and innovative, it has by no means been the only recorded attempt to provide culturally specific recovery support services to this population.

African Americans have been developing methods for caring for their addictions to drugs and alcohol for more than 100 years (White, 1999). Attempts to address these ailments through individual, group, and community efforts have been well documented. In the journal article entitled *Addiction in the African American Community: The Recovery Legacies of Frederick Douglass and Malcolm X* (White, Sanders & Sanders, 2006), it is revealed that both Misters Douglass and X (aka El Hajj Malik el Shabazz) were two of the first African Americans to publicly disclose both their drug and alcohol addiction and their approaches to recovery. According to the aforementioned authors these disclosures were made in the respective autobiographies of each. The authors report:

Abstinence-based cultural and religious revitalization movements constitute vibrant responses to the rise of alcohol and other drug problems in communities of color. Such movements often inspire culturally nuanced approaches to addiction treatment and provide culturally legitimate pathways of long-term recovery. The spark that ignites such movements is often a charismatic, recovering individual who uses his or her own personal transformation as a springboard for broad social change. This article explores what the lives of two remarkable human beings—Frederick Douglass and El Hajj Malik el Shabazz (Malcolm X)—can teach us about addiction recovery within African American communities. (p. 53)

Both Malcolm's and Frederick's history of alcohol and substance use as well as their recovery is revealed in their autobiographies, published speeches and archived correspondence (White, Sanders & Sanders). It is reported that Douglass spoke most candidly about his early drinking excesses in speeches he gave in Scotland in the mid 1800's:

I used to love drink—That’s a fact. I found in me all those characteristics leading to drunkenness. (February 18, 1846 Speech in Glasgow, Scotland)

I have had some experience with intemperance... I knew once what it was like to drink with all the ardor of an old soaker [drunkard].... Some of the slaves were not able to drink their share [portions of alcohol provided by the slave master], but I was able to drink my own and theirs too. I took it because it made me feel I was a great man.

(March 40, 1846 Speech in Paisley, Scotland)

Douglass told his Glasgow audience “...it would be an interesting experience if I should tell you how I was cured of intemperance, but I will not go into that matter now.” He never revealed those details in his writings or speeches. We do know that he signed a temperance pledge in 1845 in the presence of Father Theobald Mathew (leader of the Irish temperance movement), kept that pledge of sobriety for the remainder of his life, and went on to play a significant role in the “colored temperance movement”. (p. 53)

A century later, Malcolm Little, later to become known as Malcolm X, would learn to support his drug habit through drug dealing, pimping and burglary; describing himself as “always high” on marijuana, cocaine, and opium (Haley, 1964). In 1946, Malcolm went to prison as a result of his long-history of committing drug related crimes (Haley, 1964). While in prison he would become a member of the Nation of Islam under the leadership of the Honorable Elijah Muhammad. Through his new found religion he secured a new identity and a pathway to addiction recovery. He would also change his surname to “X,” symbolizing his defiance against his “slave name “Little”.

His new identity propelled him onto the world stage where his eloquence served as a voice for the voiceless. His defiant recovery from addiction and his unheralded outreach efforts

(what he called “fishing for the dead”) brought many addicted “Negro Men” sobriety and dignity (Haley, 1964). Malcolm’s success in overcoming his addiction and motivating other Black men into changing their drug using behaviors was buried beneath the larger controversies that surrounded his life. This was so unfortunate. However, both his life and that of Frederick Douglas would be proof that addiction and culturally specific approaches to recovery among African Americans existed long before any of the relatively new approaches referenced in this study.

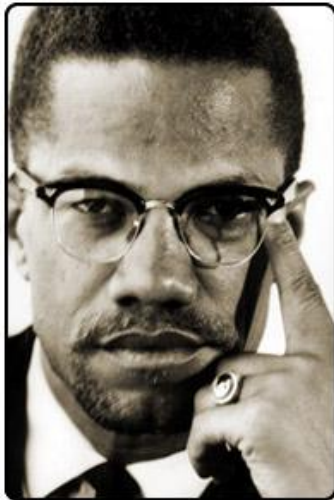


Figure 6.1. El Hajj Malik El Shabazz (aka Malcolm X)

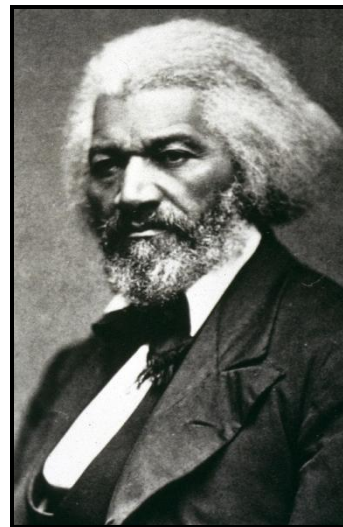


Figure 6.2. Frederick Douglass

Theoretical Implications

The social theories of Community Development, Social Action, and Afrocentrism within a Christian-based model are all interrelated in this study. Utilizing these theories as the foundation for the development of an Afrocentric, peer-led, addiction recovery program presented both challenges and rewards. This chapter will conclude with a detailed description of the benefits, detriments, challenges, and barriers associated with the adaptation of these theories.

Developing an advocacy group with members who are responsible for serving as spokespersons for marginalized substance users was an extremely rewarding experience for the staff at RCA, Inc. This effort resulted in several positive changes in attitudes and perceptions among individuals throughout. This effort has resulted in an ongoing movement aimed at ensuring parity regarding health care and treatment for substance users, raising addiction awareness and recovery realities among the general public, and reducing stigma and discrimination related to addiction and recovery; not only in Atlanta but also across America.

As mentioned earlier in this study, Faces and Voices of Recovery is a national addiction recovery advocacy organization which is responsible for encouraging changes in national policy, reducing stigma on a national level, advocating for reduction in drug related incarcerations, and promoting equal access to health care and treatment for substance users. A major emphasis of community development theory is the process of community building where the organizer creates an identification of common interests through stimulating and facilitating community awareness and involvement and the growth of citizen leadership (Tropman et al., 2001). In the case of RCA, Inc., its mission began as a movement to assist locally-based homeless substance users who were neither able to advocate for themselves nor demand the drug treatment necessary for enhancing their quality of life. Their mission has evolved to the point where they are now part of both the local and national movement; responsible for influencing national changes at both levels. These findings are examples of successful efforts at social change in the recovery support services movement.

The impetus behind and causes of the social changes that took place in this study reflected a need to adapt to changing times – the need to develop an advocacy group to represent those who were unable to advocate for themselves and the need to move from a Minnesota

model of addiction treatment to a peer-based model of addiction recovery. Homeless substance users in Atlanta were struggling for appropriate and culturally relevant treatment and recovery support services that would help them overcome their ailments and assist them in turning their lives around. Stigma, discrimination, marginalization, and insufficient funding were the dominant social problems that served as the main barriers for homeless substance users and their attempts to access care.

Community Development Theory Conclusion

This study, based in the community development theory, contributes to the literature first and foremost by providing examples of community organizing being implemented using a peer-based model. This case study has multidisciplinary implications in that it adds to the literature on addiction treatment, consumer led models, and social work practice. As mentioned earlier in the chapter on "Theoretical Framework," the intent was to use community development as a foundation theory combined with Afrocentrism and Christian-based principles, all of which lead to social change. This researcher discovered that these particular theories worked well together and complimented each other in a way that resulted in significant social change and enhancement in services specific to homeless, inner-city substance users.

This study analyzed a social problem that has been taking place within Atlanta's homeless drug using community for many years (Whiters et al., 2010). Though other Atlanta-based organizations, treatment providers, and government agencies have attempted to address this problem, outcomes produced RCA, Inc. have been unmatched as evidenced by its record setting number of more than 1100 homeless substance users being tested in one day (Whiters et al., 2010). This is not because RCA, Inc. was better funded than the others or utilized better staff than the others but because RCA, Inc. implemented a peer-based model that included staff and

volunteers who believed their own personal recovery was enhanced as a result of their involvement. This level of compassion combined with training and development led to a success that is currently unmatched among providers of services specifically designed to end substance use and its related disorders among Atlanta's homeless population. A hope of RCA, Inc. is that government agencies responsible for establishing and modifying policies related to methods and approaches for providing services to homeless substance users will seriously consider replicating this successful peer-led, faith-based model that has produced positive outcomes while simultaneously reducing the costs associated with these services.

Community development was the underpinning theory used to guide this research study which produced a deeper understanding of the roles that people in recovery play in developing support services for homeless, African American drug users. Community organizing is grounded in the distribution of shared power. Rivera and Erlich (1995) state:

It is clear that if disenfranchised communities are to be heard they need to join together, identifying common concerns and issues, and present a united front to the world outside.

It is also clear that the communities need advocates, brokers, and leaders who are able to hold together diverse interests, agendas, and strategies for change. (p. 251).

When it comes to community development specific to African Americans or people of color, Rivera and Erlich (1995) express an additional concern:

Historically, coalitions have had difficulty staying together, even when the group was homogeneous. Working with communities of color involves so many problems and so many generational, race, ethnic, and sociopolitical issues that keeping a coalition together seems almost impossible. Added to these problems are concerns over short- versus long-term issues. (p. 251).

Community development when coalesced with social action and Afrocentric theories, while based in the principles of Christianity, produced remarkable outcomes in RCA, Inc.'s based recovery support project.

Policy Implications

Policy is an idea, which is a guide to action, is written, and has the approval of legitimate authority (Tropman et al., 2001). Tropman et al., continue by stating:

Policy begins with an idea. That thought is then transformed into action guidelines. Those action guidelines are then written down, reviewed, discussed, changed, and finally approved by legitimate authority. The form of a policy can be a law, new governmental regulations, or personnel policy passed by the agency board of directors. (p. 410).

A most critical policy issue in the design and delivery of P-BRSS is the question of what is a peer and who gets to define it? There is a growing consensus among those in the peer-based movement that this right be shared equally among both the recipient and provider of services. This is an important policy issue because if state licensing boards decide that they should be the institution responsible for determining who is a peer, it is highly probable that they will require a credential beyond "self identifying as a person in recovery".

Peer is most often defined in terms of recovery status (an individual who self identifies as being in recovery from addiction and willing to provide services to others seeking recovery). However, a growing consensus among individuals involved in SAMHSA's RCSPs suggest that spouses and other family members of individuals recovering from addiction be included in the definition of a peer (Clay, 2004). For example, a spouse of a person in recovery may be able to intervene with other spouses as well as with individuals seeking recovery and provide support that leads to healing (Whiters et al., 2010; Collins et al., 2007). Peer as a definition may also

include qualities essential to the service alliance. For example, faith-based peer support programs may suggest that individuals sustaining their recovery through faith organizations only qualify as peer-leaders in the faith movement. In addition, female specific recovery programs may suggest that peers in their movement constitute other women in recovery only. In a support group for traumatized substance users being facilitated by the Triad Women's Project in south Florida, through a SAMHSA funded five-year study, it is believed that by "actively involving traumatized substance abusing women in their own recovery sends an important message of inclusion, which provides a sense of belonging and of having a meaningful role to play (Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999).

In another study conducted in Rhode Island focusing on incarcerated substance using women at risk for HIV infection, the use of peers is very important. In this study, a peer is defined as a "culturally appropriate woman from the community [urban settings where many of the incarcerated women come from] who has personal experiences with issues of heroin or cocaine use and incarceration" (Vigilante, et al., p. 410, 1999).

The reality is that there is no clear concrete definition for "what or who is a peer." It may be best if those who are involved in providing and receiving services be allowed to define for themselves what a peer is. The position that RCA, Inc. takes on this matter has been highlighted throughout this study. To RCA, Inc. a "peer" is a person who as a result of his or her own recovery is willing and able to help others secure recovery, through either individual and group counseling sessions, or both. RCA, Inc. adds one additional caveat to their definition and that is that peers be willing to enhance their skills through formal learning and training and refrain from adopting an attitude that suggest that their personal recovery from addiction, in and of itself, prepares them for their work as peers.

Credentials for Peers

Another major policy issue surrounding the movement is one of credentialing. Persons providing P-BRSS, rather than being legitimized through traditionally acquired education/credentials, tend to be legitimized based on experiential knowledge and experiential expertise (White, 2006; 2009). It is not the experience of having been wounded or having transcended such wounds that constitutes a credential it is the extraction of lessons from that experience that can aid others that transforms that learning into service to others (Whiters et al., 2010; Collins et al., 2007). This is the principle that has made AA so successful for more than 70 years. Experiential knowledge requires wisdom gained about a problem from close up or first-hand, versus second-hand knowledge. Experiential expertise requires the ability to use this knowledge to affect sustainable change in self and others. It requires the ability to separate the experience of the helper from that of the person being helped. The informal credentials of experiential knowledge and experiential expertise are granted through the addiction/recovery community through storytelling (White 2006). It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. It is a practice that has been occurring among members of 12 step recovery communities for more than 6 decades and it will be the very same principle that helps to sustain the peer-to-peer recovery movement (White, 2006). This movement, in order to be effective and sustain a life expectancy similar to AA, must remain credential free or suffer the wrath of similar movements such as addiction treatment. No legislative body can truly develop an appropriate credential for this movement unless this body consists entirely of members from the recovery community (Whiters, et al., 2010; Clay, 2004). This position does not imply a belief that only persons in recovery are able to serve as peers or that recovery in and of itself automatically prepares a person to be a

peer. This has been proven by RCA, Inc. and evidenced by its support for combining formal education with personal experiences. This has also been proven through RCA, Inc.'s decision to recruit peers from among Atlanta's faith-based communities who are not in recovery but have value through their understanding of God and Christianity.

Accountability

A final policy issue of this movement pertains to "peer-based accountability" or more appropriately a lack of accountability for peers and the movement in general. This has become a major topic of discussion among the recovery community. To what governing body is the peer movement accountable and what policies and/or procedures govern the movement that insures the safety of the clients? At the current time, no governing body exist for the P-BRSS movement, nor is there a universal "code of ethics" monitoring the actions of the peers. However, many of the RCSPs have individually begun to develop such a code (Collins et al., 2007; White, & Kurtz, 2006; Clay, 2004). This has not been an easy task primarily because a significant number of members of the peer-based movement come from 12-step recovery communities where there are no systems of accountability and no plans to implement any as evidenced by the AA tradition that says "AA should remain forever non-professional" (Alcoholics Anonymous, 1976). Aligning this movement along the lines of AA in this regard helps to insure that it remains a non-professional movement. However, an important question remains: Does this help or hinder the safeguarding of the client? The answer is "hinder," and what might be a possible solution is to encourage each individual RCSP to develop a set of ethical guidelines and share them among the groups; allowing them the opportunity to "mix and match" as needed.

Implications for Social Workers and Social Work Practice

“No clinical clients are more difficult to successfully treat than those who are chemically dependent or well along the path to addiction” (Howatt, 2003). Based on this statement, it is important that social workers, with their specialized training in serving underserved populations, be involved in developing peer-based recovery support services that focus on homeless, African American substance users.

Because the clients served in this study identified as homeless substance users and because the agency was founded by an MSW, this automatically makes this study a noteworthy contribution to the social work profession.

Social work appears to be the chosen profession for people in recovery interested in beginning, establishing, or re-establishing careers in the “helping” profession. Though there is no empirical support for this hypothesis, it remains a belief held by many within the social work profession that social work is the chosen discipline for recovering substance users pursuing formal degrees. This would not be surprising since a great number of students pursuing social work degrees are individuals who were motivated by personal issues that seemed to be healed through social work interventions. This belief is not totally supported by all as evidenced by the following Tropman et al. (2001) statement:

Most social workers haven’t been selected for their interest in, or knowledge of, poor people, especially the invisible characteristics of communities of poor people. Social workers come mostly from two groups. One group, the largest, consists of people from nonpoor backgrounds, most of whom will remain ignorant of the experience of poverty and its meanings for their entire lives. The other group is made up of people trying to escape from their poverty backgrounds and from most poor people. They are those from

among the poor who do not identify with, and who will never be of help to, persons with long-term low incomes. (p. 224)

Tropman et al. (2001) continue by stating:

Furthermore, neither social work students nor the faculties of schools of social work have often been selected as people interested in, or educated for, social change efforts, and therefore, cannot even conceptualize what is needed if poor people are to be helped. (p. 224)

This author's response to this is simply, "WOW!" The author of this study is a social worker who definitely identifies with and claims a "poor background" though some might argue that he grew up in a middle class Black family. Additionally, he certainly would not identify as a "person trying to escape poverty" though he was and is hoping for a career that will produce a salary that will allow him to live comfortably, even though many in the social work profession see this as "wishful thinking," because salaries for social workers are usually pretty minimal. In spite of Tropman et al.'s position, this author continues to argue that the poor people who are peers in this movement who are interested in combining formal learning with their life experiences will do well as students in the social work discipline.

In addition treatment an individual who decides to pursue a career in the treatment profession as a result of their own personal recovery is often times referred to as a wounded healer (White, 1998). White (1998) continues by stating that during the treatment movement of the late 1800s until the mid 1980s, more than 50 percent of the professional treatment staff were individuals who self-identified as persons in recovery. Cloud & Granfield state that:

Today, if someone with an addiction problem wanted to access help that was not grounded in the traditional approach, he or she would best be served by seeking help

from professionals in private practice. Most of them [professionals] have had training far beyond the somewhat narrow view of the disease theory of addiction (peer-based advocates would argue that the theory of addiction is anything but “narrow”). Many are able to draw on a wide range of perspectives that are generally required of them as part of their advanced professional education. Similarly, many of them are familiar with the major emerging research findings regarding the effectiveness of new as well as standard treatment approaches. They are also more likely to integrate some of these new ideas into practice with substance dependent clients (p. 75).

The professionals referenced in this quote are generally not people in recovery, though some may be, but the vast majorities include individuals with advanced degrees who work as therapists. Also, this group of professionals generally do not subscribe to the peer-based approach to addiction recovery. However, this Cloud & Granfield quote in some ways lines up with RCA, Inc.’s belief that the peer-based movement will be most effective when it includes persons in recovery who combine formal education with their personal recovery as a method for better equipping themselves to deal with the many issues raised by homeless drug users seeking recovery. Cloud and Granfield also postulate that social workers and other health care professionals [degreed individuals] possess the skill and acumen necessary for recognizing that individuals impacted by substance use must have access to options other than traditional 12-step treatment [peer-based recovery models] as a mechanism for obtaining sobriety. RCA, Inc. takes the position that peers in recovery with degrees understand this better than those in recovery without degrees or those with degrees but with no history of addiction to substances.

The literature states that a substantial number of social workers are currently employed in the addictions and mental health fields (NSDUH, 2009). In these very same fields, the social

work involvement in peer-based support services is also substantial. Specific to the mental health field, over the past several years, the practice of providing peer-to-peer support services has led to an important role for the social worker. As an example, the *Fountain House*, a clubhouse community designed to promote recovery from social isolation and deprivation commonly experienced by people with mental illness (Jackson & Purnell, 1996), located in New York City, is operated by individuals recovering from mental illness in partnership with social work staff (Jackson & Purnell, 1996). Clients utilizing this service have been successful in reducing illicit drug use and medication non-compliance (Jackson & Purnell, 1996). In the state of Georgia, another example of peer-based support services being provided by individuals recovering from mental illness in collaboration with social workers is identified. Georgia residents, recovering from mild mental illness, are eligible to participate in a state-of-the art in-depth training designed to prepare them as peers capable of providing support services for individuals impacted by both severe and mild mental illness. These services are reimbursable by Medicaid allowing the peers to generate both employment opportunities and revenue for themselves. Social workers are involved in this program from the onset, responsible for developing, analyzing, and providing key components of the training. In addition, social workers serve as supervisors to the peer-leaders, guiding them through ethical challenges and dilemmas. Though social workers don't provide direct services in this example, they are intricately involved in the day-to-day operations of this project.

Social workers interested in becoming involved in the peer-based substance use movement should begin by becoming totally educated on the disease of addiction, evidenced based interventions appropriate for clients impacted by this ailment, while researching the value of peer-to-peer support services. Social workers from a policy perspective can have a major

impact on this movement by assisting members of the recovery community in the development of advocacy groups responsible for interacting with legislators and impacting policy related to substance use funding. And, finally, social workers, through their influence, can motivate schools of social work to consider recruiting individuals from the recovery community and begin preparing them for becoming future social workers. When individuals in recovery begin to receive their credentials as social workers, for the purpose of continuing and developing the peer-based recovery movement, the movement will become more credible and effective, leading to an increase in the number of people who find recovery. This is an important position held by RCA, Inc. and a wonderful opportunity for social work education and schools of social work.

Though the level of direct practice for social workers in this current movement is limited, their value as leaders in the organizing phase, educators in the leader preparation phase, and advocates capable of influencing legislators, makes their involvement imperative. From a research perspective, the level of involvement for social workers is unlimited. A problematic situation with this movement is that there is very little if any empirical evidence in the literature to support it as a legitimate intervention. This reality makes it difficult for this intervention to be adapted by curriculums within schools of social work. However, it offers a perfect opportunity for research opportunities for social work researchers.

Social work students and educators trained in research methodologies can be intricately involved in the evaluating of peer-based support services. Their experience with conducting research on care-giving practices such as mental health prepares them for leading the research efforts on this intervention. There is truly a valuable role in this movement for the social work profession, from a practice, research, and policy perspective.

This study concludes that the need for ongoing education will continue to exist for peers in the peer-based recovery movement. This study also concludes that social will continue to be the dominant field for peers interested in advancing their education. Formal education for peer-leaders is very important. Clients with co-occurring mental and addictive disorders receiving care in a peer-based recovery support service will benefit more from peers with master degrees in social worker who are trained as mental health clinicians as opposed to peers whose sole credential is that they are recovering from substance use.

Implication for Social Work Education

The social work profession is one of our nation's leading providers of both individual and group counseling. Its training focuses on individuals, families and communities impacted by social ills including substance use disorders.

Schools of social work understand relationship between addiction, child welfare, homelessness, and other societal ills, and have accepted the responsibility for preparing students for this interrelationship through expanded curriculums focusing on various stages of addiction, abuse and recovery. Social workers, through their various employment opportunities, have familiarized themselves with the value of 12-step support programs and understand and respect programs led by peers.

An important role for social workers in the peer-based movement could be centered in the training and educating of peer leaders. Relapse prevention for substance use is an important component of the peer-based support movement. Social workers could play a major role in educating peers on "best practice" strategies regarding relapse prevention.

Another vital role that social work education might play in the peer-led recovery movement would be to develop an aggressive recruitment strategy aimed at identifying peers in

the recovery movement who could be groomed and prepared as students in social work programs. Three of the four founding members of RCA, Inc. are social workers and two earned their degrees after they started their recovery process. The founding member of this organization earned his MSW after he had sustained more than 15 years of continuous recovery. He went on to raise more than 10 million dollars in federal grant while simultaneously pursuing his PhD in social work. He was able to achieve these major accomplishments because he combined his personal experience of addiction and recovery with his MSW degree.

There are several additional opportunities for social work education in the peer-based movement. Members of the recovery community who are able to overcome their personal addictions and develop the ability to serve as peer leaders also possess the skills necessary for becoming social work students. Their personal experience combined with their skill and education development lead to the creation of one of America's formidable peer-based programs. Schools of social work could use the founding members of RCA, Inc. and others who have started their recovery from addiction and combined it with an MSW degree to actively recruit potential students from the substance use recovery community.

Social work professors could also contribute to this movement by serving as supervisors for peers and contribute by assisting the peer-based movement in the development of codes of ethics, specific to peers. And finally, schools of social work could take the lead by providing interns who could help develop, cultivate and improve the overall operation of the peer-based addiction recovery movement. There is no academic discipline that has as much to offer to this movement as social work.

Afrocentric Social Work

The role for the social work profession in the Afrocentric faith-based peer-based recovery movement, in Atlanta, is enormous. As it relates specifically to the Afrocentric paradigm, African-centered social workers, prepared through the African-centered social work training academy offered by the National Association of Black Social Workers, could command a large role in this movement. Their involvement could include facilitating training sessions for peer leaders as well as educational sessions for participants. A more formidable task could include collaborating with members of the movement and assisting in the development of curricula aimed at preparing African-centered peer-based leaders as well as ethical guidelines for the peer-based movement. In addition, because the history of social workers as care-givers is held in high regards by members of the African American community, they would be more than welcomed in the movement to develop peer-based support services for homeless drug users. This position is equal to the reverence status held by pastors and faith-leaders in the Black community. This level of respect provides opportunities for African-centered social workers to practice their advocacy training on behalf of the recovery community. They can serve as conduits to churches, businesses, schools and other institutions that can offer assistance to individuals in recovery,

Rationale for Including the Black Church

Research indicates that religion has a special prominence in the lives of African Americans, with churches assuming a particularly influential role (Taylor, 2000). Evidence in the literature demonstrates that nearly 90 percent of surveyed African Americans view the Black church as valuable and influential in a positive manner (Taylor, R. J., Chatters, L.M., Levin, L., 2004). This section focuses on the importance and value of including the Black church in the

process for providing support services to homeless substance users through RCA, Inc.'s faith-based peer-based model.

Most Black churches are experienced providers of some form of social support services (Brown, 2003, Martin & Martin, 2002, Taylor, 2000). This is not surprising considering the majority of America's Black churches are located in communities impacted by poverty, deprivation, and crime (US Department of Health and Human Services [HHS], 2001).

When viewed as an aggregate, Black Americans are considered one of the most financially challenged ethnic groups in America. In 1999, approximately 22 percent of African American families (family of 4) lived below the poverty line, while only 10 percent of all other Americans lived below the poverty line for the same period (HHS, 2001). In addition, when compared to whites, African Americans are included in the "minority" group overrepresented by a "list of overpoweringly long ailments" (HHS, 2001, p. 30). These realities have mandated the Black church to become the leader among providers of social services in the African American community.

Food and clothing banks for individuals and families in need, financial assistance for families at risk for being evicted and/or for having their utility services interrupted, temporary housing, and childcare are the services most often provided by the Black church (Brown, 2003). Along with a list of other services, Brown (2003) list substance use education among a secondary group of services most often provided by the Black church. However, in more cases than not, individuals at risk for eviction and in need of financial assistance to prevent disconnection of utilities, or in need of food and clothing assistance, particularly in urban/inner-city settings, reach this area of instability as a result of substance use. An invaluable skill possessed by peer-leaders is the ability to detect this in clients when the church leaders can not.

As referenced earlier in this study, Glide Memorial United Methodist Church in San Francisco under the leadership of the fiery Reverend Cecil Williams, during the late 1980s, in an attempt to address the crack-cocaine pandemic of the bay area African American community, developed a program using Afrocentric metaphors that compared the onslaught of crack cocaine with slavery and genocide. Williams called upon black substance users to discover the power within themselves, reframed religious/spiritual concepts to support addiction recovery, and strengthened and expanded the traditional extended family and kinship network with the Black community to support addiction recovery.

In 1948, Alcoholics Victorious was born in Chicago and offered as its core belief a connection with God, more specifically Jesus Christ, as the saving grace and cure for Alcoholism (White, 1998). In a short period to follow, another group, Alcoholics for Christ, would appear (White, 1998). Unlike Alcoholics Victorious this group advocated Alcoholics Anonymous attendance for its members suggesting they adhere to AA regulations and language such as “higher power” when attending AA, but clearly identifying Jesus as the higher power when attending Alcoholics for Christ meetings. Both these groups are examples of the role religion can and does play in addiction recovery, but neither of these programs are examples of an Afrocentric faith-based recovery model.

Several churches in the greater Atlanta area offered peer-based support groups for individuals and family members impacted by substance use. New Bethel AME, New Birth Missionary Church, The Greater Piney Grove Baptist Church, New Bethel Missionary Baptist Church, First African AME, and Stronghold Christian Church, all located in DeKalb County, GA, east of Atlanta, are Black churches that offered peer-based support services for individuals and family members impacted by addiction. Though each of these churches have predominately

African American congregations does not mean that there peer-based services are provided from an African-centered perspective. An African-centered perspective expands beyond faith and relies heavily on the strength of African practices and rituals as support for its intervention (Whiters et al., 2010; Collins, et al., 2007; MacMaster et al., 2007; White & Whiters, 2005). In addition, it encourages participants to honor, recognize and appreciate the rich history, heritage and culture of African people as a tool for developing strategies that result in a reduction of drug use, criminal activity and activities consider high risk for ongoing social ills. This is a fundamental belief and practice of the African-centered, faith- and peer-based movement.

There are several churches among RCA, Inc.'s faith-based coalition who support the African-centered approach by allowing RCA, Inc. to use their churches as venues for African-centered education sessions for homeless drug users. Simpson Street Church of Christ, The Greater Piney Grove Baptist Church, and Wheat Street Baptist Church, each located in Atlanta, and Peace Baptist Church, located in the east-Atlanta suburb, Decatur, are RCA, Inc. faith-based partners that encourage the use of their venues for education sessions. This is an example of how churches collaborate with a government funded project while simultaneously adhering to the federal mandate requiring a separation of church and state.

This author would be remised if he omitted the group that many claim has done more to liberate Black people from addiction using an Afrocentric model than all the others combined. This program, the Nation of Islam, claims to have liberated several thousand black drug users through a conversion that is truly based on African-centered principles (White, 1998). Their program, in the opinion of this author, is "Black to the Bone" because they teach that there is a direct correlation between addiction in the Black community and racism or even deeper still, genocide. Schiele (2003) is at least one African American scholar that also supports this belief.

The Nation of Islam teaches Black drug addicts how to take pride in their heritage as African people (not African American people, actually, they sometimes identify as American Africans or Africans trapped in America) and use the pride that comes from this education as the strength to overcome their addictions. As powerful as this approach is and as successful as the Nation claims it to be, RCA, Inc. has never partnered with this group to provide any services. This has clearly been identified as a mistake among some staff of RCA, Inc. It is an unshared belief among many that RCA, Inc. is partial to Christian faiths, as this is the real reason why they have not attempted to partner with a faith that has a proven track record of serving Black people addicted to drugs and alcohol.

Evidence of a Similar Successful Model

The mental health field has served as a leader of peer-to-peer support services for more than 20 years. Beginning in the 1980s, consumer-survivors (mental health term for individuals recovering from mental illness), many of them accomplished mental health professionals themselves, gave voice to the recovery vision by publishing journals (Carpenter, 2002). For more than 20 years, individuals recovering from both mild and serious mental illness have received educational training preparing them as mentors and recovery coaches (Carpenter, 2002). In Georgia, through the State Department of Human Resources, an in-depth and cross cutting training is offered to individuals with a mental illness diagnosis that prepares them for a career as a recovery coach. Recovery coaches mentor others attempting to recover from mental illness. They are certified by Medicaid as peer specialist and are allowed to bill for reimbursable services. This author is aware of at least one other state, Pennsylvania that offers this service. Carpenter (2002) also reports that there is “empirical evidence to support consumer driven

services (p. 89) resulting in increased self-esteem in both the peer-leader and the service recipient.

Consumer drop-in centers, along with housing and homeless support services, operated by individuals recovering from mental illness are some of the more common peer-based services within the mental health field (Mowbray, Robinson, & Holter, 2002). A survey of nine consumer operated drop-in programs in Pennsylvania found that successful programs exhibited effective leadership and organizational skills, a core group of invested volunteers, interdependent relationships with providers, efficient management of financial resources, planned social activities, and ongoing recruitment of new members (Kaufman et al., 1993, as reported in Mowbray, et al., 2002). This is evidence of the success that mental health peers have had in operating programs that benefit others in recovery.

In a profession closer to home, an organization of recovering social workers have developed a support group, *Social Workers Helping Social Workers*, that provides therapeutic support to social workers recovering from drug and alcohol dependence and mental illness (Stoesen, 2002). Founded in 1980 following a gathering of 50 recovering social workers, the organization developed as a national association to provide confidential assistance to colleagues (Stoesen, 2002). According to Stoesen (2002) some studies have reported that 10 to 15 percent of social workers have some type of substance use disorder, and approximately half of all social workers have seen other social work colleagues who they believe to have alcohol or drug problems. This support system is further evidence that non empirical-based interventions can be effective at producing positive outcomes. However, this program may not meet the definition of a peer-based program because it does include as a major premise a focus on individuals new to recovery.

Conclusion

The mental health movement and its advocacy groups, the National Alliance for Mental Illness and the National Association of Mental Health, have done an excellent job of lobbying for health benefits, parity, and access to treatment for individuals impacted by mental illness. In addition, the mental health movement has done an excellent job of educating the general public and key legislators on the realities of mental illness, resulting in a reduction in stigma associated with this disorder. A primary goal of the P-BRSS movement is to replicate the work of the mental health movement and successfully educate the public regarding addiction and recovery in a way that reduces stigma.

Though we have identified support for peer-to-peer services in the mental health field, less literature has been produced regarding peer-based support services for individuals and family members impacted by substance use, and even less has been produced specifically focusing on a faith-based Afrocentric model. With this reality, a suggestion by this author is to encourage addiction treatment and recovery researchers to consider focusing on randomized clinical trials evaluating the effectiveness and value of P-BRSS. This suggestion is based on the fact that the consistent reduction in treatment slots and constant increase in the number of individuals in need of services warrant studies that validate the effectiveness of alternative approaches to addiction recovery. The mental health field has successfully demonstrated value in utilizing individuals recovering from mild mental illness as mentors and recovery coaches for others impacted by mild and serious mental illness. It is time that the P-BRSS movement begin to submit journal manuscripts detailing the successes of this movement as well.

In urban America we have generations of families suffering from substance use disorders (Schiele, 2000). This spiritual ailment has resulted in the destruction of entire communities. The

faith-based, African-centered P-BRSS movement postulates that this ailment be addressed a process through that educates African Americans on the history of their culture as descendents of African people. This process, which is best facilitated by individuals grounded in the history, heritage and culture of Africa, raises self-esteem and helps to reduce the self destructive behaviors associated with drug use. This process is imperative in order for the destruction of the African American community to subside (Schiele, 2000).

Addiction impacts the Black community at the micro, mezzo, and macro levels and requires an intervention that addresses all three, not one at a time, but all at the same time (Schiele, 2000). An intervention that has been effective with this community is the African-Centered paradigm (Longshore et. al, 1998). This paradigm includes all stakeholders necessary to adequately address addiction and all other ailments within the Black community, simultaneously. It has the power to bring the faith community, clearly identified as an invaluable partner in this struggle, the educational community, since many who are involved in this movement are educators, and generations of families, an integral component of the movement, together to begin the healing process.

A third and extremely crucial recommendation focuses on a movement aimed at raising the level of education or credential for the leader of the peer movement. It is important that leaders of this movement take a critical look at the emphasis placed on “personal recovery” as not only the primary credential for this field, but also, in some cases, the only credential. The value in personal recovery has been well documented. However, several peers involved in this movement are in denial about the high level of risk for harm to clients and are not able to gauge this because they refuse to accept any position other than the one that says “individuals in recovery are best suited to serve those who are seeking recovery.” Recovery Consultants of

Atlanta, Inc. has made its position crystal clear and that position is they believe people in recovery who receive formal education are best prepared to provide P-BRSS. Whithers (2007) in the Central East ATTC publication, *Self Care: A Guide for Addiction Professionals*, cautions people in recovery working as counselors to not make the mistake of confusing their work with a program of personal recovery. A minimum standard of at least 1 year of continuous recovery combined with at least a high school equivalency might be a good place to begin. The goal of this recommendation is not to keep anyone out of the movement, but instead to better prepare those involved in the movement, resulting in an improvement of services offered to recipients.

Another recommendation relates to a policy change to health coverage regulations. Unfortunately, many health plans offer limited access to treatment for their members. Addiction is a chronic ailment similar in nature to tuberculosis and diabetes, though it is treated like an acute disease. When an individual is fortunate enough to have insurance that allows him or her to access treatment, the episode is often limited to three or four days of detoxification segueing into outpatient counseling. However, when an individual relapses, they are often times punished by not being allowed access to services a second time. This is in contrast with most other ailments. How often is a person recovering from a heart attack who has a second heart attack refused services? The true impact of P-BRSS will only take place when legislators, hospitals, and insurance carriers join with the movement and assist us in making the treatment of addiction cost effective and culturally appropriate. This will help insure that services are available to all who need and want it.

The success of the peer-based recovery support services movement offered by RCA, Inc. from a African-centered and faith-based approach is best exemplified in the more than 960 homeless men and women served by its SAMHSA RCSP grant, the more than 576 homeless men

and women treated for addiction, and the more than 1,600 homeless men and women who have been made aware of their HIV status by being tested for HIV through RCA, Inc.'s TCE: HIV grant. As a result of this work, a major increase in the quality of life for more than 2,000 homeless drug users has occurred. Table 5.4 is a descriptive report of the more than 1,600 homeless drug users who received peer-led HIV testing during the period referenced above.

Table 5.4

Report of Homeless Drug Users who Received Peer-led HIV Testing

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Race * Gender * HIV Test Results	1622	100.0%	0	.0%	1622	100.0%

Race * Gender * HIV Test Results Crosstabulation

Count			Gender			Total
HIV Test Results			Male	Female	Trans--M2F	
Positive/Reactive	Race	Black/African American	63	16		79
	Total		63	16		79
Negative	Race	American Indian/AK Native	4	0	0	4
		Asian	1	0	0	1
		Black/African American	1090	387	1	1478
		Native HI/Pac. Islander	1	0	0	1
		White	37	19	0	56
		DK	2	0	0	2
		Declined	1	0	0	1
	Total		1136	406	1	1543

Crosstabs *Trans—M2F = a person born male and has changed their gender to female

*DK – did not know

Table 5.5

Crosstabulation of Clients' Gender and Race who Received HIV Test

HIV Test Results * Gender * Race Crosstabulation

Count			Gender			Total
Race			Male	Female	Trans--M2F	
American Indian/AK Native	HIV Test Results	Negative	4			4
	Total		4			4
Asian	HIV Test Results	Negative	1			1
	Total		1			1
Black/African American	HIV Test Results	Positive/Reactive	63	16	0	79
		Negative	1090	387	1	1478
	Total		1153	403	1	1557
Native HI/Pac. Islander	HIV Test Results	Negative	1			1
	Total		1			1
White	HIV Test Results	Negative	37	19		56
	Total		37	19		56
DK	HIV Test Results	Negative	2			2
	Total		2			2
Declined	HIV Test Results	Negative	1			1
	Total		1			1

Table 5.6

HIV Risks Factors Practiced by Individuals Who Received an HIV Test

Case Processing Summary						
	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
HIV Test Results *						
Vaginal or anal sex with Male	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * Oral sex with Male	1621	99.9%	1	.1%	1622	100.0%
HIV Test Results * Vaginal or anal sex with Female	1618	99.8%	4	.2%	1622	100.0%
HIV Test Results * Oral sex with Female	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * Without using a condom	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * with person who is an IDU	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * with person who is MSM	1621	99.9%	1	.1%	1622	100.0%
HIV Test Results * with person who is HIV positive	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * used IDU in last 12 months	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * shared IDU equipment	1622	100.0%	0	.0%	1622	100.0%
HIV Test Results * Other risk 1	1519	93.6%	103	6.4%	1622	100.0%
HIV Test Results * Other risk 2	1519	93.6%	103	6.4%	1622	100.0%
HIV Test Results * Other risk 3	1519	93.6%	103	6.4%	1622	100.0%
HIV Test Results * Other risk 4	1518	93.6%	104	6.4%	1622	100.0%

- IDU – injection drug user
- MSM – males who have sex with males
- Other risk – non reported by client receiving test
- Positive/Reactive – individuals who tested positive for HIV
- Negative – individuals who tested negative for HIV

Table 5.7

*HIV Positive Test Results for Clients Receiving Test***HIV Test Results * Previous test Crosstabulation**

Count		Previous test			Total
		Yes	No	DK	
HIV Test Results	Positive/Reactive	67	12	0	79
	Negative	1313	219	11	1543
Total		1380	231	11	1622

As a result of the services provided by RCA, Inc. during the period October 2001 to September 2006, many individuals who were homeless due to drug addiction are now actively involved in 12-step and/or faith-based recovery, and many are reconnected with their families and communities. Though many of the individuals whose lives have been enhanced by the services provided by RCA, Inc. began their recovery process through traditional treatment methods, several also include individuals whose repeated attempts at traditional treatment resulted in failed efforts. However, because of their consistent involvement in P-BRSS, they are now able to sustain their recovery and have become productive members of society. This is further evidence of the positive results that have occurred as a result of the services provided by RCA, Inc. This is also evidence of the legitimate claim made by the P-BRSS movement that they belong alongside the treatment profession as an intervention that positively efforts the lives of drug users who are hopelessly addicted to drugs and alcohol.

The services provided by RCA, Inc. during the 5 year period of this study greatly enhanced the lives of many homeless drug users. Individuals who were seamlessly addicted are now productive, working and involved in the communities and faith institutions. There is no doubt in their minds or those of the staff and volunteers at RCA, Inc. that these interventions work. Not only do they work, but they are less expensive than treatment and can and are

operated by individuals whose only credential is that they themselves are in recovery. This is the one thing that makes this program so special.

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APPENDICES

APPENDIX A**Ujima Sign Posted On Rear Entry of Transitional Housing Program**

APPENDIX B

Champion Newspaper, Articles of Incorporation, and 501 (c) 3 Receipts

THE CHAMPION® NEWSPAPER
118 E. TRINITY PL. P.O. BOX 361500
DECATUR, GEORGIA 30036-1500
(404) 479-4430

1807

DATE 7/8 19 99

RECEIVED FROM David Whiters


forty & no/100

FOR Incorporation Notice

\$ 40 00
DOLLARS

Thank You

AMOUNT OF ACCOUNT	<u>40</u> <u>00</u>	<input checked="" type="checkbox"/> CASH
THIS PAYMENT	<u>40</u> <u>00</u>	<input type="checkbox"/> CHECK
BALANCE DUE	<u>0</u> <u>0</u>	<input type="checkbox"/> M.O.



OFFICE OF SECRETARY OF STATE
CORPORATIONS DIVISION
315 West Tower, #2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334-1530
(404) 866-2817

ROBERT RAY, JR.
Assistant Secretary of State -
Operations
WARREN H. RARY
Director

CATHY COX
Secretary of State

Receipt Number: **1911C**
July 8, 1999

Received From: RECOVERY CONSULTANTS OF ATLANTA, INCORPORATED

Sixty Dollars and Zero Cents

For: Articles of Incorporation

\$: 60.00

By: Carol Fuller

Regions Bank

OFFICIAL CHECK

920081746

DATE 02/14/2000

500.00
DOLLARS

PAY Five Hundred and 00/100

PAY TO THE ORDER OF **INTERNAL REVENUE SERVICE**

SDG3030

NAME OF REMITTER **RECOVERY CONSULTANTS OF ATLANTA, INC.**

REGIONS BANK

BY Phyllis J. Parsel
AUTHORIZED SIGNATURE

1022000868168110455 920081746

THE VARIABLE TONE BACKGROUND AREA OF THIS DOCUMENT CHANGES COLOR GRADUALLY AND SMOOTHLY FROM DARKER TONES AT BOTH TOP AND BOTTOM TO THE LIGHTEST TONE IN THE MIDDLE.

APPENDIX C

501 c 3 Application to IRS

Form 1023 (Rev. September 1998) Department of the Treasury Internal Revenue Service	Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code	OMB No. 1545-0058 Note: If exempt status is approved, this application will be open for public inspection.
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Read the instructions for each Part carefully.
A User Fee must be attached to this application.
 If the required information and appropriate documents are not submitted along with Form 8718 (with payment of the appropriate user fee), the application may be returned to you.
 Complete the Procedural Checklist on page 8 of the instructions.

Part I Identification of Applicant

1a Full name of organization (as shown in organizing document) <u>Recovery Consultants of Atlanta, Incorporated</u>	2 Employer identification number (EIN) (If none, see page 3 of the Specific Instructions.) <u>58-2480021</u>
1b c/o Name (if applicable) <u>David L. Whithers, President/CEO</u>	3 Name and telephone number of person to be contacted if additional information is needed <u>David Whithers</u> <u>(770) 322-8610</u>
1c Address (number and street) <u>PO Box 55279</u>	Room/Suite <u>n/a</u>
1d City, town, or post office, state, and ZIP + 4. If you have a foreign address, see Specific Instructions for Part I, page 3. <u>Atlanta, Ga 30308</u>	4 Month the annual accounting period ends <u>December</u>
1e Web site address <u>n/a</u>	5 Date incorporated or formed <u>July 8, 1999</u>
6 Check here if applying under section: a <input type="checkbox"/> 501(e) b <input type="checkbox"/> 501(f) c <input type="checkbox"/> 501(k) d <input type="checkbox"/> 501(n)	
7 Did the organization previously apply for recognition of exemption under this Code section or under any other section of the Code? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," attach an explanation.	
8 Is the organization required to file Form 990 (or Form 990-EZ)? <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach an explanation (see page 3 of the Specific Instructions).	
9 Has the organization filed Federal income tax returns or exempt organization information returns? . . . <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," state the form numbers, years filed, and Internal Revenue office where filed.	

10 Check the box for the type of organization. ATTACH A CONFORMED COPY OF THE CORRESPONDING ORGANIZING DOCUMENTS TO THE APPLICATION BEFORE MAILING. (See Specific Instructions for Part I, Line 10, on page 3.) See also Pub. 557 for examples of organizational documents.)

a ☒ **Corporation**—Attach a copy of the Articles of Incorporation (including amendments and restatements) showing approval by the appropriate state official; also include a copy of the bylaws.

b ☐ **Trust**—Attach a copy of the Trust Indenture or Agreement, including all appropriate signatures and dates.

c ☐ **Association**—Attach a copy of the Articles of Association, Constitution, or other creating document, with a declaration (see instructions) or other evidence the organization was formed by adoption of the document by more than one person; also include a copy of the bylaws.

If the organization is a corporation or an unincorporated association that has not yet adopted bylaws, check here ☐

I declare under the penalties of perjury that I am authorized to sign this application on behalf of the above organization and that I have examined this application, including the accompanying schedules and attachments, and to the best of my knowledge it is true, correct, and complete.

Please Sign Here David Whithers, msu David Whithers, President/CEO 02/23/00
 (Signature) (Type or print name and title or authority of signer) (Date)

For Paperwork Reduction Act Notice, see page 7 of the instructions. Cat. No. 17133K

APPENDIX D

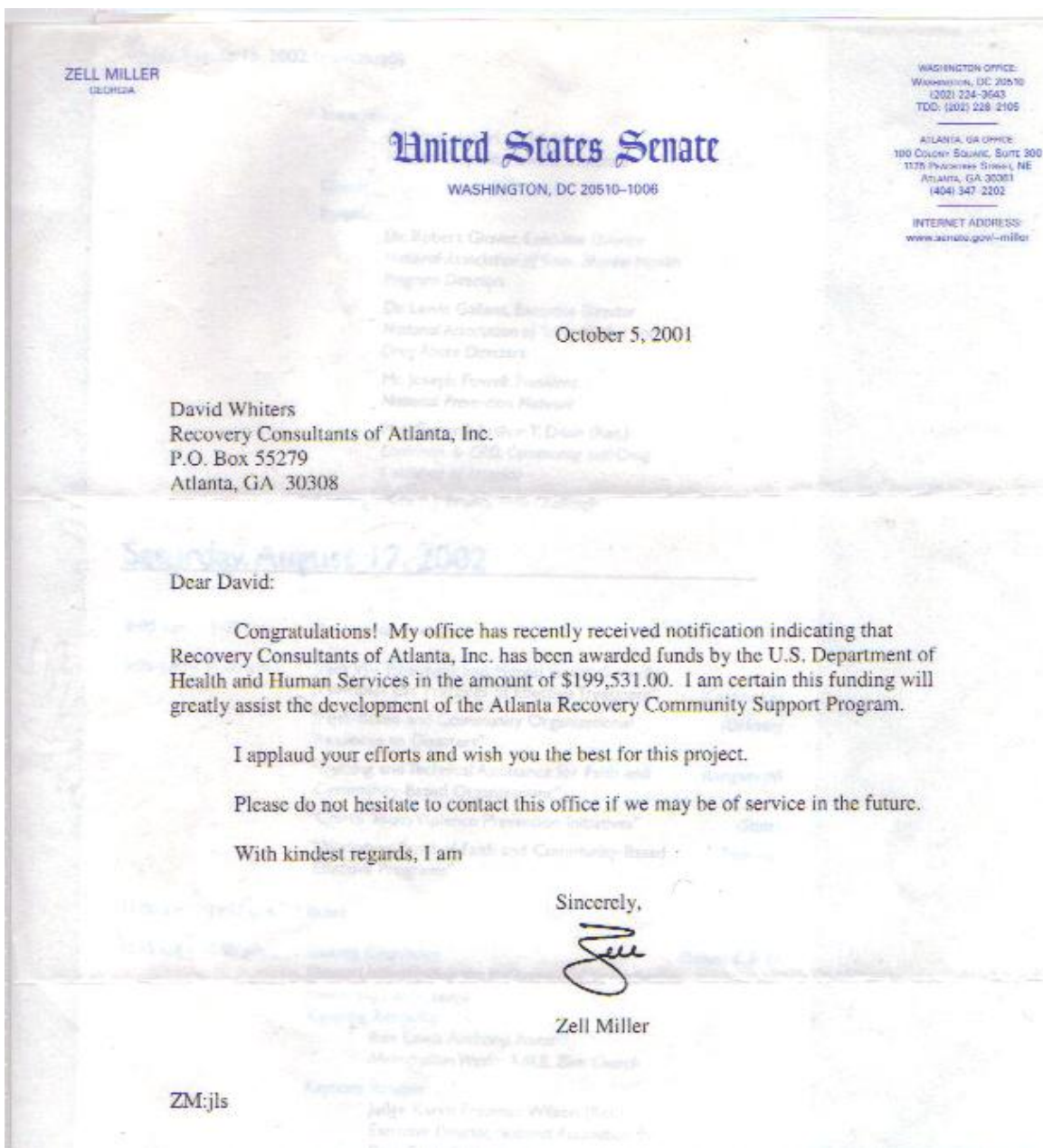
Notice of Grant Award

1. DATE ISSUED (Mo./Day/Yr.): 09/22/2001 ; CRFA NO: 93.230		DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE	
2. SUPERSEDES AWARD NOTICE (Yes/No) / / except that any additions or instructions previously imposed remain in effect unless specifically rescinded.		SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION	
4. GRANT NO. 1 H79 TI13314-01		5. ADMINISTRATIVE CODES TI-H79 / SNRT	
NOTICE OF GRANT AWARD			
AUTHORIZATION (Legislation/Regulation) Section 509 (A), PHS Act As Amended AWARDED BY CSAT			
6. PROJECT PERIOD From 09/30/2001 To 09/29/2006		7. BUDGET PERIOD From 09/30/2001 To 09/29/2002	
8. TITLE OF PROJECT (OR PROGRAM) (Limit to 55 spaces) Atlanta Recovery Community Support Program			
9. GRANTEE NAME AND ADDRESS a. Recovery Consultants of Atl, Inc b. PO Box 55279 c. d. Atlanta GA 30308		10. DIRECTOR OF PROJECT (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR) (Last Name, First and Address) Whiters, David Recovery Consultants of Atl, Inc PO Box 55279 Atlanta, Ga 30308	
11. APPROVED BUDGET (Excludes PHS Direct Assistance)		12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE	
1. PHS Grant Funds Only		a. Amount of PHS Financial Assistance (from item 11a) \$ 199,531	
2. Total project costs including grant funds and all other financial participation (Select one and place NUMERAL in box.)		b. Less Unobligated Balance From Prior Budget Periods \$ 0	
I		c. Less Cumulative Prior Award(s) This Budget Period \$ 0	
a. Salaries and Wages \$ 92,000		d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION \$ 199,531	
b. Fringe Benefits \$ 23,000		13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT)	
c. Total Personnel Costs \$ 115,000		YEAR TOTAL COSTS (DIRECT and INDIRECT)	
d. Consultant Costs \$ 0		a. 02 200,000	
e. Equipment \$ 11,600		b. 03 200,000	
f. Supplies \$ 2,000		c. 04 200,000	
g. Travel \$ 15,451		d. 05 200,000	
h. Patient Care - Inpatient \$ 0		e. N/A	
i. Outpatient \$ 0		f. N/A	
j. Alterations and Renovations \$ 0		14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)	
k. Other \$ 23,600		a. Amount of PHS Direct Assistance \$	
l. Consortium/Contractual Costs \$ 22,680		b. Less Unobligated Balance From Prior Budget Periods \$	
m. Trainee Related Expenses \$ 0		c. Less Cumulative Prior Award(s) This Budget Period \$	
n. Trainee Stipends \$ 0		d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION \$ N/A	
o. Trainee Tuition and Fees \$ 0		15. PROGRAM INCOME SUBJECT TO 45 CFR PART 14, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES. (Select One and Place LETTER in box.)	
p. Trainee Travel \$ 0		a. DEDUCTION	
q. TOTAL DIRECT COSTS \$ 190,331		b. ADDITIONAL COSTS	
r. INDIRECT COSTS (Rate 10.00 % of DIRECT COSTS) \$ 9,200		c. MATCHING	
s. TOTAL APPROVED BUDGET \$ 199,531		d. OTHER RESEARCH (Add/Deduct Option) B	
t. SBR Fee \$ 0		e. OTHER (See REMARKS)	
u. Federal Share \$ 199,531		16. THIS AWARD IS ISSUED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE PHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:	
v. Non-Federal Share \$ 0		a. The grant program legislation cited above. b. The grant program regulation cited above.	
REMARKS: (Other Terms and Conditions Attached - <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No)			
See attached terms and conditions.			
GMS: Carrillo, Pilar (301) 443-6284		PO: Nugent, Cathy (301) 443-2662	
PHS GRANTS MANAGEMENT OFFICER (Signature) <i>Stephen J Hudak</i>		Grants Management Officer, OPS SAMHSA	
17. CBL CLASS 41145		18. CRS-EN 1582480021A1	
19. ACTION ITEM NO. 2001C96T030		20. ACTION ITEM NO. 199,531	
21. ACTION ITEM NO. H9TI13214A		22. ACTION ITEM NO.	
23. ACTION ITEM NO.		24. ACTION ITEM NO.	

PHS-5152.3 (REV. 7/92) (Note: See reverse for payment information.)

APPENDIX E

Congratulatory Letter from US Senator Zell Miller



APPENDIX F

Pontiac, MI Newspaper Article Announcing Grant Award

OAKLAND

MONDAY FEBRUARY 11 2002

www.theoaklandpress.com

Ex-drug user wins \$1M grant

■ Doctoral student will use federal funds in project to rally recovering addicts

By LEE DRYDEN
Of The Oakland Press

For about 10 years of David Whithers' life in Pontiac, he was consumed by heroin use.

He took the drug intravenously until age 26. The heroin use caused him to drop out of school, and it strained relations with family members, although he adds that they never really gave up on him.

"It was all my life was about at that point," he said of his addiction.

Now, at 43, Whithers' life is about so much more. He has spent his 17 years away from drugs earning advanced degrees and helping others battle addiction.

Whithers, a first-year doctoral student at the University of Georgia School of Social Work, has received a \$1 million federal grant to assist with his efforts to teach recovering addicts to be lobbyists and leaders in substance abuse treatment and education.

"It's a movement that is similar in a

lot of ways to the gay rights movement and the civil rights movement," he said in a recent phone interview. "It's a lot of the same principles."

Whithers dropped out of Pontiac Central High School in 1976 and got his GED a year later. He doesn't hide his past problems when advocating for his cause.

"I'm one of the ones the federal government is proud of because I'll tell the whole world," he said.

But Whithers is working to convince people dealing with substance abuse that they are best-qualified to speak on the issue because they have lived with it. His goal is to "reduce the stigma associated with alcohol and drug addiction and develop advocates among the recovery community."

He said the stigma that comes with substance abuse leads most recovering addicts to remain as anonymous as possible. That anonymity makes it difficult for government officials to see the benefits of treatment programs that badly need funding.



Whithers

Whithers organized a one-day conference to convey his message to 500 recovering addicts. He wants to bring some to Washington, D.C., to help persuade lawmakers to spend money on treatment programs rather than new prisons.

The \$1 million grant came from the Center for Substance Abuse Treatment, a branch of the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. It will be used for program costs, a full-time administrative assistant and stipends for addicts who serve as advocates. He will receive \$200,000 annually for five years.

Whithers heads Recovery Consultants of Atlanta Inc., a nonprofit organization. He plans to shape his dissertation around the advocacy project.

He received his undergraduate degree at Siena Heights University in Adrian and has a master's degree from the University of Michigan. His goal is to one day teach at U-M.

As a graduate student, Whithers traveled to South Africa to tackle the problems of AIDS and substance abuse and develop prevention programs. He returned to that country for the 2000 World AIDS Conference.

Ollie Whithers, David's mother, said

he frequently returns to Pontiac to visit. She is proud of her son for overcoming his past problems to help others.

"He's always trying to help someone," she said.

Ollie Whithers has shown her motherly pride by telling everyone about her son's \$1 million grant. She even had the good news printed in the newsletter at the St. John United Methodist Church in Pontiac.

"I've shown it to everyone I could," she said.

Larry Gant, an associate professor at the U-M School of Social Work, said Whithers is a bright student who balances his academic work with his efforts to assist those dealing with substance abuse.

Drawing on his past experience, Whithers is able to relate to a wide range of people, Gant said.

"David has been outstanding and exceptional," he said. "He's a very rare individual — we need a few hundred more like him."

Whithers is pleased with how his life is progressing and embraces the challenge of combating the societal problem of substance abuse.

"There's a lot of great things happening in my life," he said.

APPENDIX G**Letter from UGA President**

May 23, 2003

Mr. David L. Whithers
4631 South Hope Springs Road
Stone Mountain, Georgia 30083

Dear Mr. Whithers:

I enjoyed reading the recent profile on you in *The Atlanta Journal-Constitution*. Your story is certainly an inspiring one, and I wish you the best as you continue your doctoral studies here.

Kind regards.

Sincerely,

A handwritten signature in dark ink, reading "Michael F. Adams".

Michael F. Adams
President

MFA/sjd

APPENDIX H

Christians in Recovery Conference Announcement



2nd Annual Christians in Recovery Conference: Promoting Faith-Based and 12-Step Recovery

Saturday, April 26, 2003
 Loudermilk Center
 40 Courtland Street *** Atlanta, Georgia
 8:00 a.m.—4:00 p.m.

RCA, Inc.
 PO Box 55279
 Atlanta, GA 30308

Featuring:

Mr. Charles G. Curie, M.A., A.C.S.W.,
 Administrator, Substance Abuse and
 Mental Health Services Administration

PRESORTED
 FIRST CLASS MAIL
 POSTAGE & FEE PAID
 PERMIT NO. 1001
 STONE MOUNTAIN, GA



CSAT
 Center for Substance Abuse Treatment
SAMHSA
 Substance Abuse and Mental Health
 Services Administration

Co-sponsored by:

The University of Georgia School of Social Work



About our Keynote Speaker

Charles G. Curie was appointed by President George W. Bush in November 2001 as Administrator of the U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is the lead federal agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental health services in the United States. Curie has over 20 years of professional experience in the mental health and substance abuse arena. His core commitment to ensuring that people with addictive and mental disorders have the opportunity to realize the dream of equal access to full participation in American society has earned him national recognition.

Before joining SAMHSA, Curie was appointed by former Governor Tom Ridge as deputy secretary for mental health and substance abuse services for the Department of Public Welfare of the State of Pennsylvania. During his tenure, he implemented a nationally recognized mental health and drug and alcohol Medicaid managed care program. He also established and implemented a policy to reduce and ultimately eliminate the use of seclusion and restraint practices in the state hospital system. The program won the 2000 Innovations in American Government Award sponsored by Harvard University's John F. Kennedy School of Government, the Ford Foundation, and the Council on Excellence in Government.

Previously, Curie was the Director of Risk Management Services for Henry S. Lehr Inc. in Bethlehem; President/CEO of the Helen H. Stevens Community Mental Health Center in Carlisle, Cumberland County; and Executive Director/CEO of the Sandusky Valley Center in Tiffin, Ohio.

Curie's passion and commitment for service started in his early childhood when he began to hold leadership positions at church, school and community activities. Among Curie's many community and civic activities include past member of the Board of Directors of the Greater Carlisle Chamber of Commerce, Chairman of the Greater Carlisle United Way Annual Campaign, member, Rotary International, member of the advisory board, Tiffin Mercy Hospital, president of the Huntington College Student Union and Senate Member, Huntington College Board of Trustees, and president of Alpha Sigma Eta Fraternity at Huntington College.

Registration form

(Please use one form per person and reproduce as needed)

Name _____

Agency (Optional) _____

Address (home or work) _____

City _____ State _____ Zip _____

Phone () _____ email _____

Exhibit space yes no (Must purchase early group rate package (250.00) in order to exhibit)

Make check payable to:
Recovery Consultants of Atlanta, Inc.
PO Box 55279
Atlanta, GA 30308

DISCLAIMER

This conference was funded in part by a grant from the Center for Substance Abuse Treatment (CSAT), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA), in the U.S. Department of Health and Human Services (DHHS). The support provided by CSAT does not in any way imply endorsement of the views or comments made by speakers or presenters at this conference. Individual comments or perspectives should not to be interpreted as the official view of any federal agency. The contents of this conference are solely the responsibility of the conveners and do not necessarily represent the views of CSAT, SAMHSA, or DHHS.

Recovery Consultants of Atlanta, Inc.

April 26, 2003

To the Conference Attendees:

On behalf of the volunteers, sponsors, and well wishers who worked diligently to make today's conference a reality, I would like to thank each of you for your support and prayers. Today's conference is a culmination of your support and commitment.

Our conference host, Christians in Recovery (CIR), is a program of Recovery Consultants of Atlanta, Inc. – A SAMHSA/CSAT funded faith-based, peer-based Recovery Community Services Program. CIR's membership includes representatives from more than 20 local churches, 2 Historically Black Colleges and Universities, and several recovery and community based organizations. The fruit of the committee's labor has resulted in our 2nd annual faith-based conference. We are proud of this year's event and we believe this endeavor is a true reflection of God's will for us.

Again, on behalf of all of those who have helped to make today a reality, I would like to thank you for your patronage. I pray that today's conference moves you in a way that proves beyond a shadow of a doubt that through God all things are possible.

Sincerely,

David L. Whiter

David L. Whiter

Our Preamble

Christians in Recovery (CIR) is a program of Recovery Consultants of Atlanta, Inc. (RCA, Inc.), a SAMHSA/CSAT funded faith-based, peer-based Recovery Community Services Program (RCSP). Founded by concerned, committed, and spiritually centered members of metro-Atlanta's 12-step recovery community, our goal includes collaborating with Atlanta area faith institutions and Historically Black Colleges and Universities (HBCUs) and developing and implementing programs that benefit individuals in recovery and those in need of recovery.

Our current collaborative includes 6 Atlanta area churches, 2 HBCUs, and 10 transitional housing programs. Together we provide services that include but not limited to transportation and child care for parents seeking both faith based and 12 step support group services, "pre-recovery" education for children of parents seeking recovery, a free-monthly training for individuals in recovery pursuing certification as addiction counselors, transitional housing for individuals and families in early recovery, and HIV/substance use prevention education for faith institutions and Atlanta area recovery clubs.

The debate that one approach to recovery, faith-based vs. 12-step, is more effective than the other has no place in the peer-based recovery movement. Promoting a message that both approaches are effective at reducing relapse and sustaining long-term recovery is CIR's mission. The members of CIR believe the responsibility for promoting this message lies within the recovery community. We are the experts on this issue and therefore responsible for spreading this message. We accept the reality that in order to articulate this position in a manner that is both effective and receptive, we must first learn to communicate to broad based audiences. Due to the nature of addiction, many members of the recovery community have not been involved in social circles where communicating positive messages was important. Today, as a result of our personal recovery, we are learning how important this is; not only for ourselves as individuals, but also as empowerment agents for substance using individuals caught in the web of addiction.

Our drug using experiences and subsequent recovery has propelled us into the forefront as spokespersons for those seeking services. Many within the recovery community lack the resources necessary for empowering themselves to the point where they alone can seek out services. Stigma related to substance use disorders, the unwillingness of many to accept addiction as a brain disorder, and stereotypes towards people of color and recovering substance using offenders, are barriers that make seeking services difficult, and in some cases impossible. Our faith-based model is designed to reach the greatest number of those in need. In order to achieve this goal, we must offer multiple roads to recovery. Recognizing the value in multiple approaches to recovery is the role of the responsible recovery member.

CIR has concluded that a coalescing of the recovery community is compulsory if we are to successfully promote the message that faith-based, peer-based support services are effective, cost efficient, and easy to replicate in both faith and secular communities. Faith-based, peer-based support services have proven successful at helping reshape the lives of individuals and families impacted by the horror of drug and alcohol addiction.

"The paramount goal is compassionate results, and private and charitable groups, **including religious ones**, should have the fullest opportunity permitted by law to compete on a level playing field, so long as they achieve valid public purposes...The delivery of social services must be results-oriented and should value the bedrock principles of pluralism, nondiscrimination, evenhandedness, and neutrality."

President George W. Bush

January 29, 2001

From UNLEVELED PLAYING FIELD: Barriers to Participation by Faith-Based and Community Organizations in Federal Social Service Programs

<http://www.whitehouse.gov/news/releases/2001/08/unlevelfield.html>

Programme

8:00 – 8:45

Registration/Continental Breakfast

8:45

Opening Prayer

Praise and Worship Service Featuring

New Bethel AME Church – Praise Team

9:00

Conference Overview

9:10 – 9:45

Opening Spiritual Speaker

Reverend Rodney Turner, Antioch North Baptist Church

10:00 am – 11:45 am

Morning Breakout Sessions

12:00

Lunch

Luncheon Speaker

Ms. Tracy Leach, Mount Sinai Church of Austell

1:15 pm – 2:45 pm

Afternoon Breakout Sessions

3:00

Keynote Address

**Mr. Charles G. Curie, M.A., A.C.S.W., Administrator,
Substance Abuse and Mental Health Services Administration**

Workshops

A review of the Good book and the Big book: In search of common themes

Presenters:

Marlow Beavers

Reverend Kelvin Turner

Embracing Recovery: The role clergy and lay leaders play in the peer-based recovery movement (am only)

Presenters:

Cosby Eskridge

Chaplain Gayle Jordan

Maximizing your faith institution's resources: How to develop and implement peer-led, faith-based initiatives

Moderator:

James "Jimi" Allen

Presenters:

Ms. Sharon White

Donald Gregg

Our Diversity is our Strength: A panel presentation of Asian, Latino, East African and Islamic peer-led, faith-based initiatives (pm only)

Moderator:

Onaje Salim

Presenters:

Pierluigi Mancini, PhD

Sung Hyun Yun

What do we mean when we say "faith-based, peer-based initiative?"

Moderator:

Rozell Green

Presenters:

Gregg Crawford

Steve Walker

A peer-based approach for addressing addictive and mental health disorders

Presenter: NAMI

HIV & Substance use prevention for urban adolescents: A peer-led, faith-based initiative

Presenters:

Ms. Tiffiany Cummings

Reverend Will Hayes

Announcements

EVALUATIONS

We are asking all attendees to complete **2** evaluations at the end of the conference. The first evaluation form (white pages) is a government document referred to as GPRA. Please complete both the consent form, listing only the last 4 digits of your social security number as your identifying code, and the attached pages. **The attached pages must have the same identifying code as the consent form.** In addition, there is an “overall conference” evaluation form (Fuqua color) that we need you to complete. Please take your time and complete the evaluations in their entirety. These documents are presented to supporting federal agencies and are used to justify financial assistance for future conferences.

CEUS and NAADAC Contact Hours

The UGA School of Social Work has approved this workshop for 5 CEUs for MSW, MFT, and LPC, and 5 contact hours through NAADAC for CAC. **YOU MUST** complete a form (**White form**), in its entirety, **YOU MUST** print legibly, and **YOU MUST** sign your name and list your social security number. A certificate will be mailed to you by May 26th. You **ONLY NEED** to complete this form if you are interested in CEUs and/or NAADAC contact hours.

KEYNOTE ADDRESS

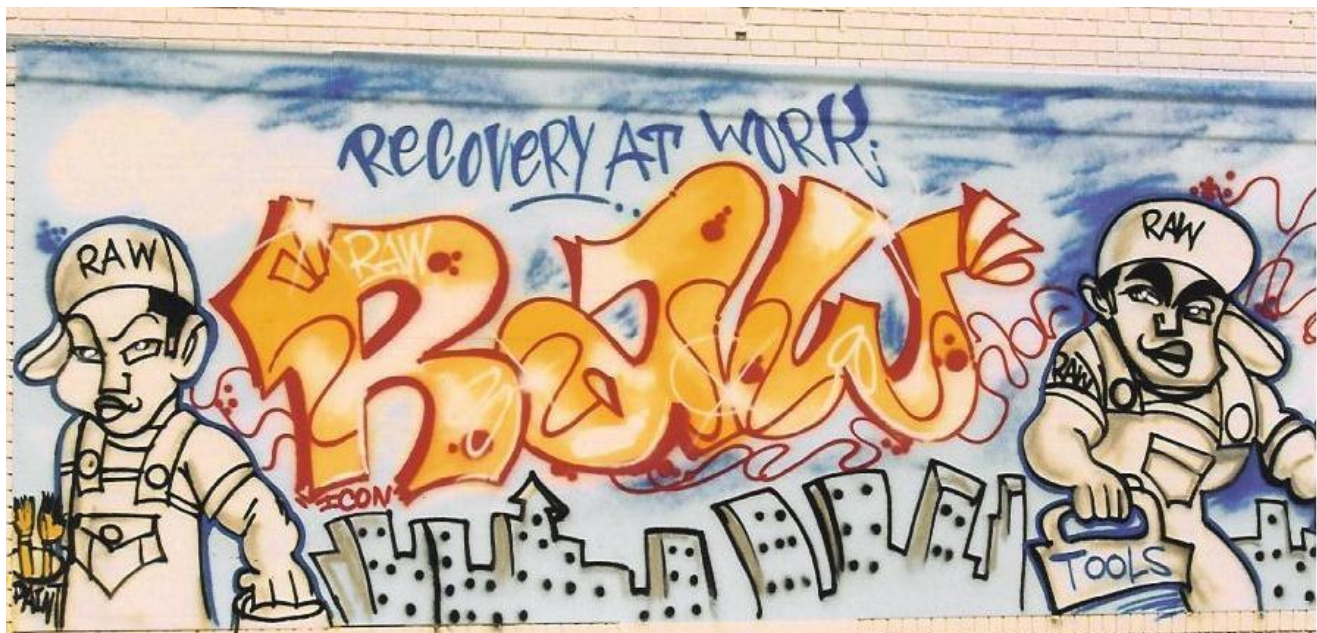
It is extremely important that everyone attend the closing keynote address. Mr. Charles G. Curie, Administrator, Substance Abuse Mental Health Services Administration, is our speaker. It is important that we show him a great deal of respect and appreciation by showing up to support him.

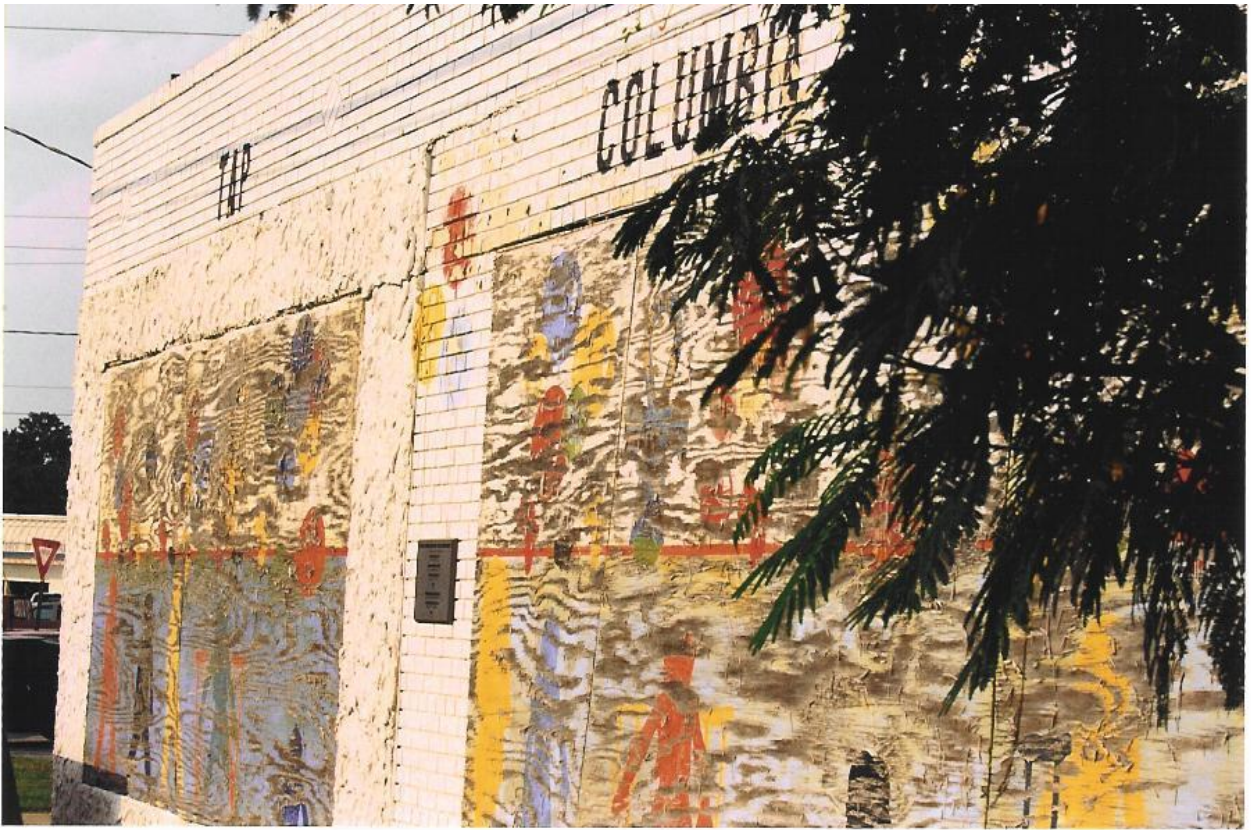
SAVE THE DATE

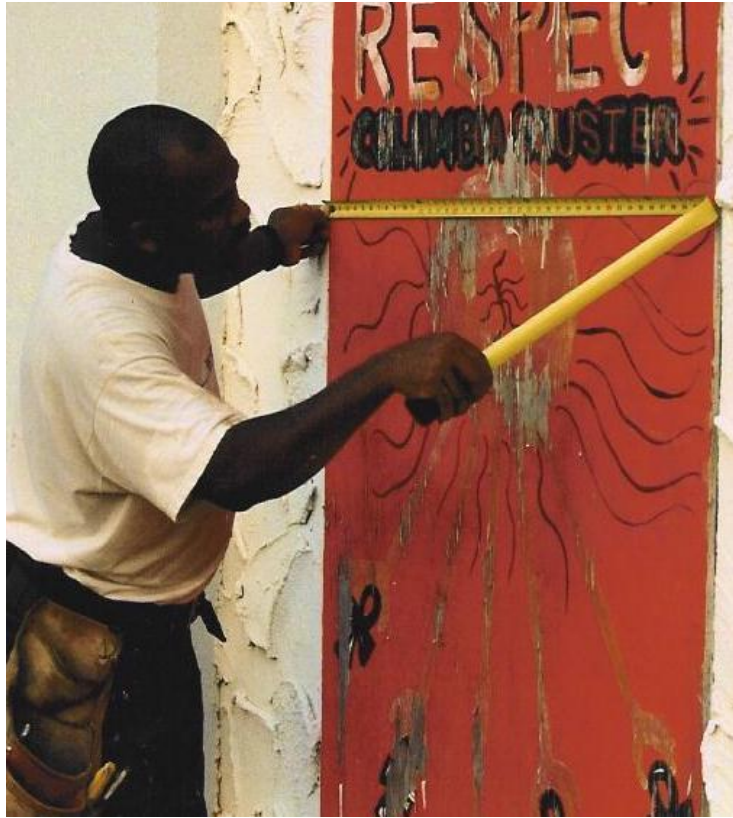
Our next major event will be our “Recovery Month” celebration. On Monday and Tuesday, September 15 - 16, 2003, we will host a 2 day forum, celebrating recovery, featuring William “Bill” White, famed lecturer and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. If you are interested in helping to plan this event, please complete a volunteer form and leave it at the registration desk. Someone will contact you soon.

APPENDIX I

Recovery Month Mural



APPENDIX J**Worn-out Mural Painted in 1993 by Columbia Cluster of TAP**

APPENDIX K**Old Mural Being Replaced by Men in the RAW program**

APPENDIX L

Recovery Members Signing the Wall



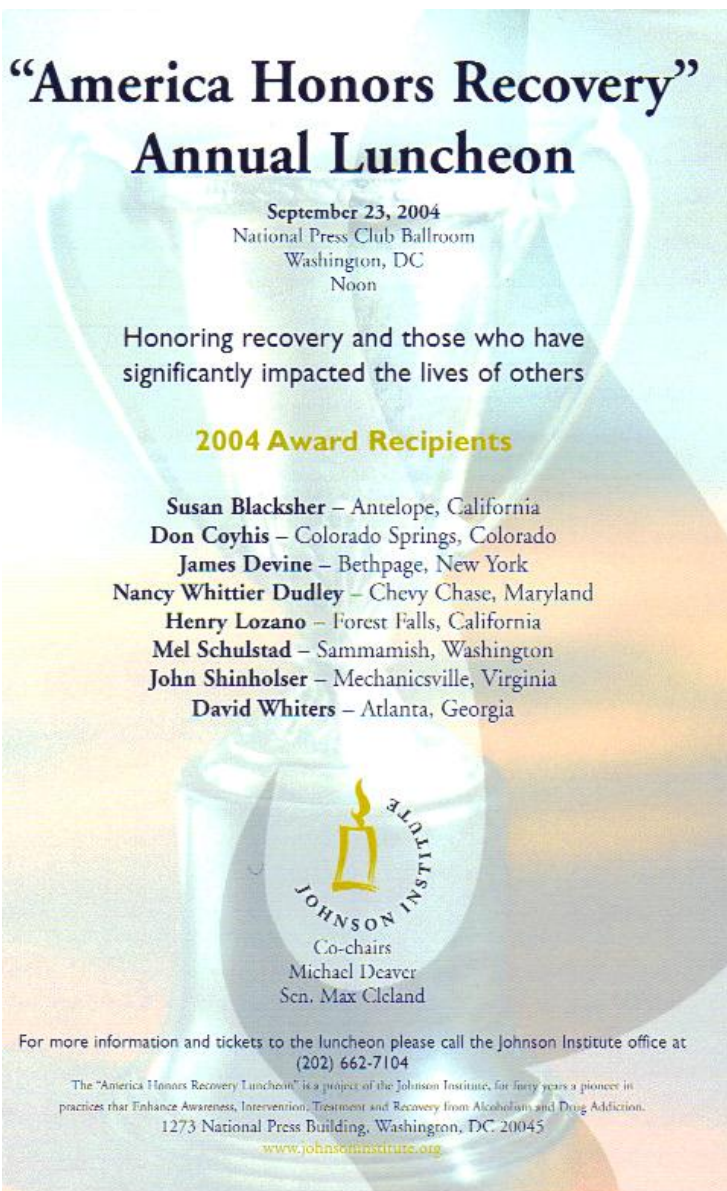
APPENDIX M

Cassandra Collins, MSW and RCA, Inc. Associate Director and Bill White



APPENDIX N

America Honors Recovery Award




**“America Honors Recovery”
Annual Luncheon**

September 23, 2004
National Press Club Ballroom
Washington, DC
Noon

Honoring recovery and those who have
significantly impacted the lives of others

2004 Award Recipients

Susan Blacksher – Antelope, California
Don Coyhis – Colorado Springs, Colorado
James Devine – Bethpage, New York
Nancy Whittier Dudley – Chevy Chase, Maryland
Henry Lozano – Forest Falls, California
Mel Schulstad – Sammamish, Washington
John Shinholser – Mechanicsville, Virginia
David Whitters – Atlanta, Georgia


Co-chairs
Michael Deaver
Sen. Max Cleland

For more information and tickets to the luncheon please call the Johnson Institute office at
(202) 662-7104

The “America Honors Recovery Luncheon” is a project of the Johnson Institute, for forty years a pioneer in
practices that enhance Awareness, Intervention, Treatment and Recovery from Alcoholism and Drug Addiction.
1273 National Press Building, Washington, DC 20045
www.johnsoninstitute.org



"America Honors Recovery" Annual Luncheon

"The power to *conquer*
addiction is in the faces, voices, and actions of
recovered people, their families and allies."

"America Honors Recovery" Luncheon
Thursday, September 23, 2004
National Press Club Ballroom
529 14th Street NW
Washington, DC
Noon

"America Honors Recovery" Luncheon Ticket Order Form

☐ \$200.00 General admission ☐ \$140.00 National Forum Participants

Total # of tickets _____

Total \$ _____

Name: _____

Organization: _____

Address: _____

City: _____

State: _____

Zip: _____

Telephone: _____

Fax: _____

Email: _____

☐ Check enclosed

☐ Please send invoice

All orders must be received by Thursday, September 16, 2004 to insure ticket delivery.
Make checks payable to Johnson Institute. The Johnson Institute is a 501(c)(3) organization.
Contributions supporting "America Honors Recovery" Luncheon are tax deductible.
Tickets are limited. Tickets will be sent to the address provided on this form.
For further information, contact the Johnson Institute office at (202) 652-7104.