Contents

Building Our Recovery Communities

MEETING AND INSTITUTES OVERVIEW

INTRODUCTION

Building Our Recovery Communities was a meeting for Recovery Community Support Program (RCSP) grantees sponsored by the Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration (SAMHSA).

This meeting was attended by representatives of 19 local or State projects to develop communities of people in recovery from addiction, their significant others, and supporters. Their goals, set forth in the CSAT grant guidelines, were:

- To empower recovery organizations to participate in the planning, delivery, and evaluation of substance abuse policy and services, so that services become increasingly consumer-driven and responsive to consumer needs.
- To promote linkages among recovery organizations, persons from self-help programs, and family support groups, and to facilitate linkages between such individuals/organizations and formal delivery systems.

- To reduce the stigma associated with addiction, treatment, and recovery.
- To foster financial self-sufficiency and independence of recovery organizations (transition from Federal grant funding to other public and private resources) over the term of the Federal grant.
- To document organizational structures and processes used by recovery organizations in their efforts to become viable advocacy groups for substance abuse treatment.

At the time of the meeting, RCSP grantees were almost nine months into their three-year grants. As expected in an innovative program, many grantees had encountered start-up challenges, but most were well launched into project activities.

The *Building Our Recovery Communities* meeting was designed as an opportunity to share experiences in the development of organizations to provide the recovery community with a public voice. It also was intended to provide the opportunity for participants to reflect upon lessons learned to date and address knowledge and skill needs identified by the grantees and CSAT. Grantees played a significant role in shaping both the content and the design of the meeting.

This summary of the second Grantee Meeting and Training Institutes can be viewed as a "snapshot" of grantees' thinking and experiences approximately nine months after the RCSP grants were awarded.

■ AGENDA AND STRUCTURE OF THE MEETING

As detailed in the Agenda, presented as Appendix II, the Grantee Meeting and Training Institutes consisted of four types of sessions:

1. **Plenary** presentations and community meetings;
2. Three parallel **tracks** — consisting of **two Institutes** (one on organizational development and the other on community mobilization) and **one Recovery Community Dialogue** (on power, anonymity, and stigma);
3. Grantee **Team Meetings**; and
4. Optional **evening events** focusing on issues and initiatives of particular interest to the recovery community.

All sessions were interactive, emphasizing learning from one another, and focused on integrating and applying knowledge and skills to the particular challenges facing the recovery community, as it attempts to find a voice in improving this country's addiction treatment policies and systems.

1. Plenary Meetings

Designed to focus on issues of importance to all participants, the Plenary sessions included:

A. An opening Plenary in which a panel of consumer and family representatives from the mental health, physical disabilities, and HIV/AIDS communities were invited to share with the RCSP grantees their constituency-building experiences. This panel was followed by a facilitated discussion of the themes and challenges that the panel identified. Meeting participants were invited to share their experiences in the application of these lessons to the particular challenges facing the addiction recovery community.

Meeting Report No. 1 summarizes the highlights of the opening Plenary.

B. A keynote address by Dr. Terry Tafoya, a national leader in community-building, who demonstrated the power of the story and shared principles of cross-cultural communication that can be applied effectively in recovery community organizing to ensure understanding among a membership reflecting diversity.

Meeting Report No. 2 summarizes the highlights of Dr. Tafoya's presentation.

C. A facilitated presentation, discussion, and panel on a "Discussion Draft of Case Study Guidelines." This session was designed to enable the grantees and CSAT to reach consensus on guidelines for the case studies that are required of each RCSP grantee and that are intended to communicate to the field lessons learned from the RCSP. The guidelines are presented in Appendix I.

D. A presentation on legal and ethical issues, including guidance on the prohibition of lobbying with Federal funds and protection of participants' confidentiality in RCSP activities.

E. A closing performance by Mark Lundholm, recovery comedian and inspirational speaker.

2. Institutes and Dialogue

At the core of the Grantee Meeting were two parallel **Institutes**, one on **Organizational Development** and the other on **Community Mobilization**, and a parallel **Recovery Community Dialogue** on concepts that are important to the recovery community (**power, anonymity, and stigma**). These concepts are integrally related to the efforts of RCSP grantees to provide vehicles for the recovery community to participate in the public dialogue about addiction, treatment, and recovery.

The Institutes and Dialogue were designed, first, to build knowledge and skills in the two areas that have most engaged RCSP grantees in the early months of their grants — building organizational infrastructure while simultaneously working to engage and retain the recovery community in their efforts. Second, but of no less importance, the Institutes and Dialogue were intended to bring to the table the hard-won wisdom and values of the recovery community to inform the organizing and mobilizing efforts of grantees and others.

Meeting Report No. 3 is a summary of the highlights of the Recovery Community Dialogue on power, anonymity, and stigma. Some of these concepts are also explored or referenced in **Meeting Report No. 4** on community mobilization and **Meeting Report No. 5** on organizational development

3. Team Meetings

Grant project teams typically split up to attend different Institute and Dialogue sessions. Team Meetings, where teams regrouped, were a key component of the design of the Grantee Meeting and Training Institutes. They provided an opportunity for project teams to synthesize insights gathered from the Plenaries, Institutes, and Dialogue, and to apply these insights to their own projects. In addition, several project teams attended the Team Meetings sessions together. RCSP grantees are a diverse group of organizations who utilize varied organizing strategies and are embarked on an array of activities. Therefore, Team Meetings also offered an opportunity to share issues and ideas across projects.

4. Optional Evening Topic Meetings

The Grantee Meeting and Training Institutes was principally a community- and skills-building event. However, *Building Our Recovery Communities* also included optional evening events that permitted participants to discuss current issues for the recovery community in small informal settings.

A. A focus group on **SAMHSA Consumer/Family Materials on Managed Care Contracting**. As managed care has emerged as the leading model for delivering mental health and addiction treatment services, SAMHSA has developed a series of educational and training materials for consumers and families who wish to engage in managed care contracting/quality assurance processes. Are these materials accessible to consumers and families in the addiction recovery community? Do these materials fully reflect the concerns of this community? This focus group explored these questions and offered suggestions for making the SAMHSA materials relevant and accessible to the recovery community.

B. A discussion group on **Federal and State Issues on Parity.** Parity has emerged as a central issue galvanizing providers, consumers, and families across the behavioral health spectrum. Although many of the debates directly affect them, consumers and families from the addiction recovery community have frequently been uninformed. This was an opportunity for RCSP grantees to receive current information on parity issues, including the relationship between the mental health and addiction recovery communities.

C. SAMHSA, in conjunction with the Office of National Drug Control Policy (ONDCP) and the U.S. Department of Justice, convened a special session to solicit grantee comment on **the ONDCP Draft Policy Statement** on *Establishing a Continuum of Accountability, Treatment and Rehabilitation for Drug-dependent Criminal Offenders: The Elements of a Policy for the 21st Century.* Comments made by meeting participants included general support for the need for treatment in corrections settings, a concern that treatment is increasingly moving from the community into treatment of late-stage chemical dependency in our jails and prisons, and suggestions for ways to avoid language that stigmatizes offenders in treatment.

D. A special forum was convened with RCSP grantees to provide testimony and direction in a **Call for Grantee Comment on the CSAT National Treatment Plan.** This forum, in which all participants at the Grantee Meeting and Training Institutes were invited to participate, provided an opportunity to give recovery community input into the design and the priorities of the addiction treatment system of the 21st century. Testimony covered both matters that are of general concern in the recovery community (such as the invidious role of stigma in reducing recovery opportunities) and personal testimony on the power of recovery and the value of treatment. This was the first public hearing in a series of hearings across the country convened by CSAT to elicit public opinion that would contribute to a refocusing of CSAT initiatives to improve addiction treatment in the new millennium.

■ MEETING REPORT NO. 1

Building Our Recovery Communities:

GRANTEE MEETING AND TRAINING INSTITUTES

Highlights from Opening Plenary Panel:

BORROWED FOUNDATIONS AND NEW STRUCTURES

Moderated by Rick Sampson, Director of CSAT's Division of State and Community Assistance, this panel offered the wisdom and experience of consumer leaders from the mental health, physical disability, and HIV/AIDS constituency movements.

Larry Belcher is the Chief Executive Officer of the West Virginia Mental Health Consumers Association in Charleston, West Virginia. He also directs a consumer organization and technical assistance center under the auspices of the Center for Mental Health Services, SAMHSA.

Myra Hill, Baltimore, Maryland, has served for many years on the HIV Prevention Community Planning Group for the State of Maryland and is now its Co-Chair. She knows from firsthand experience the challenges and benefits of including consumer perspectives in planning prevention, intervention, and treatment services.

Anthony Tusler is well-known both for his strategic thinking and his ability to conceptualize about issues and relationships in the physical disability communities. Mr. Tusler is Coordinator of the Disability Resources Department of Santa Rosa Junior College in Santa Rosa, California.

The panelists were asked to frame their remarks around three areas of questioning:

- **Community Definition:** Who defines the members of your community? What is the balance of self-definition, social designation, and professional assessment in that definition? What is the role of allies in your community? Who is in? Who is out?
- **Community Empowerment**: What issues has your community struggled with in its movement toward becoming an empowered advocacy constituency? What strategies have been effective in addressing these issues? (For example, how have you addressed issues of territoriality, limited resources, and other potential or actual conflicts?)
- **Differences and Diversity:** How does your community deal with the diversity of its primary membership? How does your community deal with diversity issues outside the primary community identity, such as gender, race, ethnicity, sexual orientation, age, class, and disability?

Meeting participants were invited to identify issues and challenges that they heard from the panel and that they recognized from their RCSP work. They also were invited to identify unique characteristics or conditions of the addiction recovery community that might require new or different solutions.

■ COMMUNITY DEFINITION

Panelists and meeting participants agreed that **language** presents serious threshold difficulties. Participants reported, for example, that the term **substance abuse** offends many in the recovery community, since it implicitly puts the entire responsibility for addiction on the addicted person without acknowledging the presence of disease. The term **consumer** is also distasteful to many, with its overtones of consumption of substances crowding out the marketplace analogy it is meant to suggest — the person who receives addiction treatment as the consumer of services. The concept of the recipient of treatment services as a consumer is new to the recipients themselves.

◗ ON LANGUAGE

"When we start to define ourselves, we have to be careful. Sometimes we stigmatize ourselves."— Panelist

"When we say 'substance abuse,' that suggests we chose to be addicted. The language defines the issue." — Meeting participant

One panelist introduced the concept of **internalized oppression** to explain how stigmatized people can internalize and then perpetuate society's negative images about them. Recovery community experiences of the phenomenon of internalized stigma also were explored during the Recovery Community Dialogue session on stigma, and it was identified as a key organizing challenge for RCSP grantees.

◗ ON INTERNALIZED OPPRESSION

"In some consumer and family groups in my disability area, I've seen a lot of behavior that reminds me of early recovery: lots of misplaced anger, hurt egos, thinking there won't be enough to go around. To me, that's the face of internalized oppression. It's what happens to us when we've been hurt out there in the world." — Panelist

Who's in and who's out? Who is included in the **recovery community**? This issue was only touched upon during the Plenary session, although during subsequent meeting sessions, particularly the Dialogue on power, it became clear that RCSP grantees were struggling to answer this question. What is **recovery**? What is a **community**? Are groups imposing **length of sobriety** tests? Is sobriety the only measuring rod, or are other people, such as people on methadone maintenance, part of the recovery community? What about families? What about people in recovery who are also treatment providers? Who decides who's in and who's out of the community? What's the difference between someone who's in and someone who's out, but also is an ally?

◗ WHO'S IN, WHO'S OUT?

"I found that everything I thought was problematic has been addressed in my recovery. How sober did you have to be? The only requirement is a desire to quit drinking. In that broad sense, we need to say that anyone willing to work on our issue should have a place at the table." — Panelist

Related issues on the subject of ***allies*** attracted attention during the Plenary session. Both panelists and meeting participants subscribed to the "big tent" premise: Anyone who wants to work on our issues is welcome. But cautionary notes were sounded. Building alliances requires an ability to recognize appropriate roles and respect boundaries, an understanding of who the players are and what they care about, and an ability and willingness to give as well as to take.

◗ ON ALLIES

"We have to be careful about our allies. What I look for in an ally is somebody who has a certain amount of familiarity with roles. Welcome the allies, but be tough with them." — Panelist

"We are learning that, in forming alliances, you need to have some strengths to bring to the table. And you need to know what they are. You need to understand your ally's strengths, and your ally's agenda, too." — Meeting participant

"We have a local mental health association that voted to support our effort and advocate for us on an issue. We thought this was wonderful. Then they asked us to do a return favor and we weren't ready to deal with that. Forming alliances is a two-way street." — Meeting participant

■ COMMUNITY EMPOWERMENT

Panelists agreed that issues of power, both within consumer and family organizations and in other groups in which consumers and families participate, are critically important.

◗ POWER IN THE ORGANIZATION

"Do an analysis of power in the organization or group — is it walking the walk or just talking the talk? Who's rewarded, who's not? Who gets to do what? When? Are people just working through their own thoughts? Honor that and move on!" — Panelist

Their recommendations were to emphasize common ***values***, ***vision***, and ***mission***.

◗ ON VALUES

"For a recovery community organization to function properly, it has to be values-based. We're talking about recovery from addiction here. This process comes from inside. To think we can use external means to resolve conflict in such an organization is a mistake." — Panelist

One panelist talked about **tokenism.** There is a large demand for recovery community participation on various boards, panels, task forces, etc. People who serve in the token position often have many concerns: What can I contribute? Will I be taken seriously? How do I avoid being co-opted? The panelists emphasized that there is no single answer, but recommended starting by asking lots of questions. Consumers and families are not expected to know everything, and **asking questions** shows a willingness to learn and to get involved. Paraphrasing back in your own words, and in terms of your own experience, sends a signal that you are coming to the group from your own perspective and your own understanding of the subject, but are open to understanding theirs.

◗ ON ASKING QUESTIONS

"Everybody wants to have a consumer or family member in their group, whether they mean to listen to them or not, and there aren't enough people to go around. I start by asking a lot of questions and then paraphrasing back. That starts to get the group to think of you as an asset." — Panelist

The more questions you ask, the more learning you will do. The more you learn, the less chance there is that you will be co-opted or become a token.

◗ On learning

"What will open the door is being educated on the issues. You don't need a degree, but you need to be able to converse and be knowledgeable about what you are advocating for." — Panelist

■ DIFFERENCES AND DIVERSITY

Panelists concurred that questions of differences and diversity within their individual communities encompass more than external factors such as gender, race, sexual orientation, ethnicity, age, and class. For example, within a disability group, **fragmentation** often occurs. People will often fragment along such fault lines as: 1) the nature of their diagnosis; 2) their relationship to the diagnosis, e.g., the person with the diagnosis (primary consumer) versus the member of the family (secondary consumer) of the person diagnosed with a disability; 3) their experiences with the treatment system; and 4) different levels of stigma. People in wheelchairs may think they belong in a different group than people with impairment of cognitive function. People with schizophrenia may think that their needs are completely different from the needs of those who suffer from depression. People who contracted HIV/AIDS through sexual activity may feel they should be distinguished from those who contracted the disease from intravenous drug use, and vice versa. Primary and secondary consumers of services may articulate their values and goals in different terms.

◗ On inclusiveness

"The HIV/AIDS community, to be effective, has to be inclusive of those infected and those affected. The same is true of the addiction recovery community." — Panelist

◗ On diversity

"Developing a community with diversity means being open to the idea that each person brings something beautiful and contributes to the rainbow." — Panelist

One panelist expressed the view that it is the primary challenge of **organizational development**, as well as of the organization's leadership, to keep an organization integrated in the face of challenges to commonality and the inherent tendency of many self-directed groups to break into their constituent parts.

◗ On differences and disintegration

"Most organizations begin with an idea that sounds good. Then people begin to question, which isn't necessarily a bad thing, but can create differences. There needs to be some tension to be alive. Sometimes groups go off, do their thing, and don't get reintegrated into the whole." — Panelist

Committees, for example, can be vehicles for developing different perspectives, but it is important to have a mechanism for integrating these perspectives into an overarching perspective of the group as a whole.

Another panelist pointed out that, for a variety of reasons, segments of a community with important interests in common may wind up in different organizations. Even when that is the case, he added, collaboration is key. In the end, he said, whether it is intraorganizational or interorganizational, "It's all about relationships."

◗ On collaboration

"Collaboration can be as important as inclusiveness. In my State, consumer groups have collaborative relationships with many other organizations. We may have different values, which means we may not agree about everything. But, if we look hard enough, we find things to agree about." — Panelist

■ MEETING REPORT NO. 2

Building Our Recovery Communities:

GRANTEE MEETING AND TRAINING INSTITUTES

Highlights from Keynote Address:

BUILDING COMMUNITY

by Dr. Terry Tafoya

Terry Tafoya, Ph.D., often relies on his training as a Native American storyteller in his work as a Family Therapist and Senior Staff Member of the Interpersonal Psychotherapy Clinic, University of Washington Medical School. At the University, he trains and supervises medical residents in their psychiatric rotations. Dr. Tafoya also is Professor of Psychology at Evergreen State College, where he directs programs in transcultural counseling. He is the first Native Healer formally recognized by the Washington State Department of Social and Health Services.

Dr. Tafoya drew on a variety of sources, from academic learning to folk tales, to illustrate principles of community organization. He used various techniques, ranging from storytelling to the exploration of myths, to make important points that can be useful to Recovery Community Support Program (RCSP)

projects. Listening to him enabled the audience to focus on "gems" of community development wisdom that could be used to derive suggested principles helpful in building a recovery community organization (RCO). Here are just a few:

Sociologist Clyde Kluckholm asked Euro-Americans, African Americans, Mormons, and non-Mormons in the Southwest: "How would you bring a well to your community?" He found that what differed in their answers was the priority given to various choices that had to be made along the way. Everyone agreed on the desired outcome, and everyone had the same potential choices. But they described very different ways of bringing a well to the community.

▲ **Principle —**
Don't assume that people who share your goal will accept your analysis of the problem or your strategies for achieving a solution. Don't expect everyone to agree with you or with each other, or to respond to the same challenge in the same way.

Everyone agrees that effective communication is crucial, but how do you create the appropriate conditions for communicating your message? Some people learn from listening to the facts; other people learn better from stories. Native American Elders, for example, may use stories of conquering evil beings as an analogy to overcoming a disease.

▲ **Principle —**
Stories are powerful tools to explore people's fears and concerns about a disease and begin to change the way they relate to the disease. The stories work best when they are told in a familiar setting by a storyteller to a group that is comfortable with one another. The story builds on what the group already knows and believes.

In working with members of a Latino community, an HIV/AIDS outreach worker's attempt to talk with men failed completely until he talked with them in a social setting where alcohol was served and "sex talk" was deemed appropriate. His attempt to talk to females failed completely. So a female outreach worker was hired to go into the communities where the infection was prevalent and talk just with women. The only women who would talk to her were sex workers. Part of her outreach became an effort to encourage the sex workers to carry the message to other women in the community.

Linguistic patterns influence both what we say and what we hear. Research demonstrates that a person will not process communication in English fully as a native speaker until the language has been spoken by three consecutive generations of his or her family.

▲ **Principle —**
Build your communication and outreach strategy around community norms, roles, and mores.

For example, most languages have a culturally appropriate pause time. A pause by the person talking means that the listener can speak now. A pause of 20 seconds lasts a long time, but still may not be long enough to give some people cultural permission to speak. Some cultures have traditions for mediating pause time. One reason Native American communities create talking circles is so they can pass around an object that everyone can see, and only the person holding the object can speak. But there is a Jewish saying that illustrates that, in other cultures, erasing the pause time by interrupting to say something before the speaker has finished may show enthusiastic support rather than disrespect: "When a man's heart is on fire, sparks will fly from his mouth."

▲ **Principle —**
It is easy for cross-cultural communication to fail because of missed cues and misinterpreted sounds and silences. Leaders have to come up with creative ways to make sure people are truly heard.

People hold both primary and secondary world views — and these views may be logically inconsistent. A person's primary world view may be based on theories of biomedical research, while folk beliefs inform his or her secondary world view. A person may believe that an infection is triggered by a virus, while his secondary world view is based on a folk belief that disease is God's punishment for sin or for bad behavior. Both views influence how he perceives such illnesses as AIDS and addiction.

Historically, the primary world view of most Americans has been that addiction is a moral problem. For many, this remains the primary world view, even if they have begun to grasp that there are important biochemical dimensions of addiction. For others, a biochemical disease model has become the primary world view. But even for most of them — even those who have personally experienced addiction and recovery — the secondary world view of addiction as a "moral problem" remains. It is human nature, in a conflict situation, to revert to the view that is most likely to convince the person one is talking to, or in times of stress, to fall back on the comfortable secondary world view.

▲ **Principle —**
Just because a person publicly subscribes to a primary world view that addiction is a disease doesn't mean that he doesn't have a secondary world view that addiction is a "moral problem." This is as true of people in the recovery community as it is of anyone else. Frequently, the secondary world view emerges in times of stress or conflict.

Feminist psychologist Carol S. Pearson says that we all go through a series of life stages on our heroic journey toward self-discovery and realization of our full humanity. This heroic quest is full of dangers, but it also offers great rewards: the capacity to be effective in the world, knowledge of the mysteries of the human soul, and the power to find and express one's unique gifts and talents.

According to Pearson, we use twelve archetypes — inner guides based on mythological stories of heroes — to organize our experience and guide our journey. At times, we may get fixated in a stage or stuck on a particular archetype, or we may be thrust back into a stage we thought we had completed. When we are out of touch with our authentic life journey, we lose our sense of wholeness and integrity.

It is interesting that many of the characters in our best-loved stories have archetypal counterparts. For example, Dorothy, in *The Wizard of Oz*, can be seen as the orphan — the homeless person who gets involved with a giant force, and, among other things, overdoses on poppy. Many people you deal with in recovery communities will be in the orphan position. They may not be able to see what you want them to see. You may see that they have talent, but they will be blind to their own capabilities.

▲ PRINCIPLE —
PEOPLE WHO HAVE SUFFERED OR BEEN MARGINALIZED — SUCH AS MANY PEOPLE IN EARLY RECOVERY — ARE LIKE ORPHANS, AND WILL OFTEN LOOK TO AN EXTERNAL SOURCE FOR DIRECTION. "TELL ME WHAT TO DO, AND I WILL DO IT." AS AN ENGINE OF EMPOWERMENT, AN RCO CAN HELP PEOPLE IN THE ORPHAN POSITION RECOGNIZE THEIR CAPABILITIES.

Dorothy goes through many of Pearson's archetypal stages during her adventure in Oz. In the caretaker stage, Dorothy uses her power on behalf of others: She attacks the lion to rescue the dog; she liquidates the witch to save the scarecrow. At the end of the story, Dorothy realizes her personal power and moves into the stage of the magician. With help from the good witch, Dorothy finally understands that she has had the capability all along, in the ruby slippers, to power her journey home.

▲ PRINCIPLE —
PEOPLE DO ADVANCE FROM ONE ARCHETYPAL LEVEL TO ANOTHER . . . AND YOU CAN HELP THEM ALONG.

People behave as they have been socialized to behave and according to where they are developmentally on their journey. Warriors see the world as black and white. You are either their ally or their enemy. Even if your group works very successfully in advancing the interests of a member, she may attack you if she is a warrior.

Many people believe that to be a good American, you must fit a mold that was actually never meant for you: You must be good all the time, be a Christian, be male, be heterosexual, be financially successful. If you don't fit the model, you believe that you will never make it through life. That message can be overwhelming. Many people feel their lives — and personal identities — have been ripped apart by having to force themselves into the mold. Many turn to alcohol and drugs to medicate themselves against the pain of such dismemberment. They may be in recovery now, but may still believe they have to fit the mold or they will not be worthy of respect.

In recovery, many people still feel dismembered and traumatized. They are not yet whole. The act of helping people become whole again is sacred. Having their identity and worth recognized by the RCO, as they make a contribution to the organization's work, becomes a deep healing — a way of "remembering" their wholeness.

▲ PRINCIPLE —
HELPING PEOPLE IN RECOVERY PUT THEMSELVES BACK TOGETHER IS A SACRED ACT. BUILDING A RECOVERY COMMUNITY IS AN EXTENSION OF THIS SACRED ACT.

As your members grow in confidence and skill, they can help build a recovery movement that will assist the Nation in developing a primary world view of addiction as a disease, and of treatment and recovery from the disease as courageous and heroic acts.

Thank you to you who are leading this movement.

▲ PRINCIPLE —
BUILDING A RECOVERY COMMUNITY IS A SACRED ACT CONDUCTED ON BEHALF OF EVERYONE.

■ MEETING REPORT NO. 3

Building Our Recovery Communities:

GRANTEE MEETING AND TRAINING INSTITUTES

Highlights from Recovery Community Dialogue

ON POWER, ANONYMITY, AND STIGMA

Facilitated by Billie Alexander Avery (facilitator and consultant from Pengram, Tennessee), the Recovery Community Dialogue was designed to discuss concepts of importance in the recovery community — power, anonymity, and stigma— and to explore how these concepts relate to Recovery Community Support Program (RCSP) organizational development and community mobilization efforts.

Each session of the Recovery Community Dialogue started with a list of suggested questions. In many cases, the Dialogue unfolded around the questions asked, but in other cases, the Dialogue took off in unanticipated directions. The themes and issues that emerged were characterized by paradox and by a sense on the part of participants that their own thinking was evolving.

Although participants did not always agree with one another, the Dialogue was respectful of individual differences. The general conclusion of the participants was that hard discussions are hard work and that establishing an environment of mutual trust and respect was an essential precondition to fruitful dialogue.

This Report summarizes the highlights of the Recovery Community Dialogue. Participants were quick to suggest recovery community organization (RCO) tips based on the dialogue themes and were very candid in putting out on the table the issues with which they are wrestling.

■ SESSION ONE: POWER

Session One of the Dialogue focused on power, powerlessness, and empowerment, exploring these concepts from traditional addiction recovery perspectives, as well as from other viewpoints, with a view to integrating them into the organizational development and community mobilization efforts of RCSP grantees.

Suggested questions included:

- Can one person empower another, or is empowerment an internal process?
- What have we learned in recovery about personal power? About the power of our experience, strength, and hope (our story)?
- What have we learned about the power of language and communication?
- How can we deal with disparity of power and power struggles within our organization and community groups?
- How is accepting our own power consistent with and/or threatening to our recovery?
- What are the implications of what we have discussed for building a recovery community organization and mobilizing a recovery community constituency?

Paradigms (and Paradoxes) of Power and Empowerment

Many participants drew upon their 12-Step backgrounds when asked to discuss power and empowerment:

- "It's only through admitting powerlessness over one domain in your life — drugs and alcohol — that you can find your power in other domains."

- "At the root of your power is your willingness to give it away. Without sharing, there is no true power."
- "The hardest thing for me to learn during my son's treatment was that I was powerless over his addiction, that I had to detach and all of that. Now I seem to be thinking that I have the power to change national addiction policy. Is this healthy?"

Others brought different perspectives to the table:

- "Power was one of the first things that Saul Alinsky talked about. Power is not bad, nor is it good. It is neutral. What's important, and what isn't neutral, is where and when power is used."
- "Power means different things depending on the preposition that follows it. Power over . . . power within . . . power among . . . each of these is subtly different."
- "Power is really about resources. Who has or controls which resources really explains differentials in power."

Some participants spoke of the power of resources:

- "Our grant is within an institution that has power in the administration of the grant. Still, we members have spiritual resources. It's not all about the dollars."
- "CSAT opened a door, used its power and resources to mandate certain processes. Other agencies have done the same — CDC mandates HIV community participation for many grant programs, for example. But when our CSAT funding runs out, can we sustain? That will be the true test of our power."

Empowerment was seen as an internal process on the one hand, but also as a process that can be facilitated by others.

◗ Power and Vision

"Having a vision provided for me was important to me in the beginning. The more we talked about it, the more motivated we got. This gave me the power to stand up and say what I thought should be in the vision statement. I was surprised I could have a part in the process, but I did it, and WOW!" — Meeting participant

Some participants pointed to a tension between emphasis on a functional hierarchy so that goals can be achieved and deference to grassroots members, who may not see its importance. They suggested that this tension could be a creative source of organizational development and maturity. On the other hand, if not properly channeled, the tension could lead to anarchy.

☛ *Tip*

Facilitating Empowerment

Participants identified collective and continuing work on organizational values, vision and mission as key empowerment tools, as well as tools for steering the organization through developmental stages and resolving conflict when it occurs. Some participants also reported that it had helped them to bring in an outside facilitator for important sessions of this nature. An outside facilitator highlights the significance of the event for members, reinforces the value of their contributions, and provides project staff with an opportunity to take a back seat and listen and learn.

Language and Empowerment

Discussion of the power of language, the need for nonstigmatizing terminology, and the pervasive absence of clear definitions for commonly used words was woven through the Recovery Community Dialogue on power, as well as other meeting contexts.

Participants repeatedly noted that calling someone a "substance abuser" overlooks the disease aspects of drug and alcohol "abuse" and reduces the problem to one that can be resolved if only the recalcitrant individual will "just say no" and stop "abusing" the substance.

> ◗ **On power and language**
> *"I don't know if I ever abused substances — certainly I used them, and maybe I abused them. But eventually I was not abusing them, they were abusing me. That was terrible abuse, it was miserable, and it never let up. It was like being locked in prison with no key. And for some of us, prison wasn't even a metaphor."* — Meeting participant

Many in the recovery community are also uncomfortable with the term "consumer" and would prefer to use "recovering" as the identifier. Some object to the confusing question of what kind of consumption is being referenced (the consumption of alcohol or other drugs as opposed to the consumption of services). Others, for a variety of reasons, feel excluded by the term "consumer."

> ◗ **On power and language**
> *"People currently or recently in treatment have no idea that the term 'consumer' refers to them, and they're confused when they hear it. And people in recovery who never went through treatment, or who now also define themselves as recovering treatment professionals, feel excluded by the term."* — Meeting participant

In this session, as in other meeting contexts, participants found objectionable many of the adjectives routinely applied, even by the well-intentioned, to addicts and their behavior around drugs and alcohol.

> ◗ **On power and language**
> *"When have you ever heard of a 'hard core' diabetic? And when some people — sadly not just in criminal justice, but even in the treatment world — link addiction to 'other aberrant behaviors,' I feel sick. I feel as if they are taking my addiction and my core personal being — my sexual orientation — and wrapping me up as dehumanized trash."* — Meeting participant

Language defines the nature of the problem, identifies the players, and can marginalize the nonplayers, considering them as belonging to an inferior class of people. Overcoming the obstacles presented by current terminology is, in the view of the Dialogue participants, a key empowerment challenge for the recovery community.

Defining the "Recovery Community"

RCSP grantees have a definitional problem of their own: Just what is the "recovery community?" The RCSP Guidelines for Applicants provided latitude for each grantee to develop a working definition in light of its mission and goals. Not surprisingly, different grantees are facing different definitional challenges.

Abstinence-based only? Although many of the RCSP grantees have strong roots in abstinence-based (often 12-Step) recovery strategies, some have rejected an organizing strategy limiting membership to people with these roots. Most have opted for generic and undefined references to "recovery" and a number have purged their language of references to sobriety and of key phrases identified with the 12 Steps to ensure that the use of such phrases does not cause others in recovery to feel left out. A few have actively sought to engage members of the methadone maintenance community in RCO activities and are struggling with the task of integrating two very different recovery cultures.

◗ On power and differences

"Our group now has both 12-Step and methadone maintenance members. We 12-Steppers feel afraid, even threatened, but we are beginning a process of mutual education and are beginning to wonder if this new dynamic could increase the power of both groups to affect meaningful change." — Meeting participant

Tests for length of sobriety? Only one or two RCSP grantees impose a "length-of-sobriety" test for membership or participation in RCO activities. Some participants suggested that they had expected members would want such a requirement, but, as one participant put it: "Our members didn't go for it and thought it was patronizing." One organization that does impose a test for the length of sobriety explains it as both a relapse prevention measure and a means of reducing the public visibility of early relapse.

◗ On empowerment and length of sobriety

"When I thought about this project ahead of time, I imagined that a person's eligibility to participate would turn on length of sobriety. It has turned out to be a non-issue. This doesn't mean we don't worry about relapse — we do — but length of sobriety is not the only indicator. In fact, it's a poor test of advocacy readiness." — Meeting participant

Role of Two Hatters? In no case has an RCSP grantee defined membership in its RCO in such a way as to exclude "two-hatters" — i.e., persons in recovery who are also treatment professionals. A few participants voiced concern about whether two-hatters might control the RCO agenda, or expressed concern that the mission of an advocacy RCO could be compromised if the RCO is viewed as a soapbox for drawing attention to providers' professional concerns. Other par-

☛ *Tip*

RCSP ISSUE: What is the "Recovery Community?"

With different missions, goals, and target communities, each RCSP grantee faces its own particular issues in defining "who's in and who's out" of its organizing effort. At least four different emerging "hot definitional issues" surfaced during the Recovery Community Dialogue on power:

- Is "recovery" limited to abstinence-based approaches?
- In an abstinence-based context, are organizations imposing "length-of-sobriety" tests for membership or leadership?
- What should be the role of "two hatters," i.e., recovering treatment professionals, in an RCO?
- What is the role of allies? Are they in — or are they out, but partners?

There are no right answers to these questions — the Dialogue revealed only that RCOs are beginning to wrestle with the issues, not that they've resolved them.

☛ *Tip*

Working with Recovery Newcomers

Although typically not imposing length-of-sobriety tests for membership, some RCOs are developing strategies for engaging recovery newcomers. These strategies include:

- Working with surveys and other low-disclosure vehicles to solicit input and views from those still in treatment or new to recovery.
- Developing peer mentor programs within the organization.
- Phasing members into leadership roles.

☛ *Tip*

One Organizational Solution Involving Two-Hatters

One RCSP grantee reported that, although welcome and even recruited as members, two-hatters had been phased off its RCO Board of Directors largely in response to concerns about control of the RCO agenda and perceived potential compromise of the RCO advocacy mission. This grantee did not want to lose the many benefits of its good relationship with providers, however, and established a Professional Advisory Committee to channel support and concerns of providers — not just two-hatters — to the RCO.

ticipants, however, noted the importance of two-hatter energy and knowledge in an environment where many in the recovery community are stigmatized, marginalized, and generally unfamiliar with system advocacy issues.

Role of Allies? A number of grantees reported defining the recovery community with language such as "individuals in recovery, their families, and allies." One reason advanced for such a broad definition has been the desire to attract members without making RCO membership tantamount to self-disclosure. Participants did not discuss whether this broad definition including allies will have organizational development or other implications in the evolution of RCOs.

■ SESSION TWO: ANONYMITY AND STIGMA

Session Two of the Dialogue focused on the interrelated, but distinct, concepts of anonymity and stigma.

ANONYMITY

Suggested questions relating to anonymity included:

- What is the difference between anonymity and confidentiality? Anonymity and stigma?
- What is the purpose of anonymity in 12-Step programs? In treatment programs?
- How does anonymity relate to the themes we have discussed regarding power?
- Can you be an advocate and retain your anonymity?
- How can a recovery organization honor traditions of anonymity and nevertheless build a public voice?
- What are the implications of this Dialogue for building a recovery community organization and mobilizing a recovery community constituency?

Anonymity and 12-Step Traditions. Participants used the term "anonymity" as a shorthand reference to a set of principles and practices embedded in 12-Step Traditions (especially Traditions 6, 10, and 11). Purposes for anonymity identified by the participants included:

- Keeping 12-Step groups from becoming enmeshed in any public controversy that would divert them from their primary purpose of helping alcoholics and addicts to get sober, and
- Fostering personal humility, which is a cornerstone of the spiritual foundation of 12-Step recovery.

Participants agreed that advocacy, including the telling of one's personal story in a public forum, could be done in a manner entirely consistent with 12-Step traditions of anonymity. They reported, for example, that they consistently urge that members who are 12-Steppers not identify themselves as such when they give personal testimony. Many RCOs use the brochure *Advocacy with Anonymity* as a teaching tool and as a vehicle for clarifying some of the differences between the RCO and a 12-Step program.

Participants reported that the risk that RCO activities would violate 12-Step Traditions relating to anonymity worried some in the recovery community more than others. Several participants reported their perception that "old timers" in AA were more likely to raise the issue than were newcomers to recovery. The consensus was that it was better not to push someone who felt strongly about this but to move on as a group.

◗ AN ANONYMITY WATCHDOG

"We recruited an old-timer who joined for the express purpose of making sure we did not violate 12-Step Traditions. We appreciate his help, and he has turned out to be a great recruiter of others with long-term sobriety." — Meeting participant

Rewards and Risks of "Going Public." Throughout the Dialogue, participants returned to the healing power of telling one's story — a healing that was seen as encompassing both the storyteller and the listener. As one participant put it, there can be something therapeutic about standing up in a public place, acknowledging who you are, and advocating not only on behalf of your own needs, but also the needs of others with whom you feel kinship. "Responsibility and citizenship are recovery values," he said.

◗ POWER OF THE STORY

"My first feeling of empowerment came when I got up and told my story. My knees were knocking together; it takes courage to find a voice and speak for yourself. But that is what our organizations have to do." — Meeting participant

"Personal stories in this program are unique and powerful. They are the stories of heroes. There is a power of using each one's story to bring people together." — Meeting participant

☛ *Tip*

ADVOCACY WITH ANONYMITY

Most participants reported that *Advocacy with Anonymity,* a brochure on advocacy in the context of 12-Step Traditions prepared by Join Together and the National Council on Alcoholism and Drug Dependence, was an invaluable resource. Grantees have used it as a handout, as a teaching tool, and as a stimulus to discussion in their groups.

☛ *Tip*

MANAGING THE RISKS OF GOING PUBLIC

A number of participants made suggestions for managing the risks of self-disclosure, including:

- Never push people to tell their story.
- People can contribute in ways other than telling their story.
- Phase in levels of involvement (and disclosure), especially for people in early recovery.
- Help people understand that there are different consequences to telling one's story in various settings and that it is okay to decide when and where, and what parts of one's story, to share.
- Help people think about the risks in advance.
- Remind people that telling their own story doesn't mean they have permission to tell anyone else's story.
- Telling one's story can be emotional and traumatic — It is important to "be there" for people who need to debrief.

At the same time, participants recognized risks in going public, particularly relating to:

- Relapse (especially for people new to recovery), and
- Exposure to stigma.

A number of suggestions were made for reducing these risks, but a sense was also expressed that this is a new area, people are still feeling their way, and more recovery community dialogue has to occur on this subject.

◗ RELAPSE

"If one person loses recovery because of a false sense of power, we have sold our mission down the river. We have an obligation, with all humility, to look out for our brothers and sisters and, if we see someone in trouble, reach out and help them." — Meeting participant

STIGMA

As the Recovery Community Dialogue turned to stigma, a new set of questions was put on the table:

- What is the social purpose of stigma generally? As it relates to addiction?
- Who has a vested interest in perpetuating addiction-related stigma?
- What is the opposite of stigma?
- What kind of double (or triple or quadruple) stigmas operate in relation to addiction?
- How do we in the recovery community deal with stigma among ourselves?
- What stigma-reduction strategies have worked?
- What are the implications of what we have discussed for building a recovery community organization and mobilizing a recovery constituency?

The nature of stigma and how it is perpetuated. Starting with dictionary definitions of stigma (a "mark of shame or discredit," an "identifying mark," or a "mark of hot iron"), participants moved on to identify some of the social purposes that stigma is understood to serve, including:

- Expressing disapproval and serving as a form of social control. This is believed to discourage certain behaviors that do not conform to generally accepted standards and norms.

◗ STIGMA AND SOCIAL CONTROL

"Part of our cultural myth is that we can control things. The out-of-control behavior of alcoholics and addicts is both fascinating and frightening to us. As a culture, we have a love/hate relationship with drunkenness. Just look at recent movies such as 'Leaving Las Vegas' and 'Unforgiven'." — Meeting participant

- Reducing fear and a sense of vulnerability by blaming the victim.

◗ STIGMA AND FEAR

"I stigmatize what I fear in or for myself. My ignorance is a component of my fear — don't confuse me with the facts." — Meeting participant

Dialogue participants also suggested that some groups in society benefit from the continued stigmatization of addiction because it allows their system or organization to maintain itself or grow. For example:

- The criminal justice system (to expand capacity).
- Insurance companies (to reduce costs).
- The media (to promote sensationalism).
- Persons promoting prevention strategies that emphasize fear and intense disapproval.

Many participants also recognized that the recovery community, by remaining largely out of public view, shares some responsibility for the perpetuation of stigma.

◗ STIGMA AND ANONYMITY

"Recovery is (or should be) a vehicle for destigmatization, but we have sometimes hidden behind anonymity (which, in actuality, is often fear of exposing ourselves to stigma) and that compounds the problem." — Meeting participant

How do we in the recovery community deal among ourselves with stigma?

This question provoked perhaps the most searching self-examination that occurred during the Recovery Community Dialogue. Participants began to explore how members of the recovery community often "buy in," through internalizing oppression, to the stigma and help perpetuate it. They also related this to the organizing challenges faced by RCOs.

☛ *Tip*

RCSP ISSUE : RCOs AND RELAPSE

Unlike 12-Step or treatment programs, the primary mission of RCSP RCOs is not to promote individual members' recovery or to engage its members in relapse prevention activities, even though these may be secondary gains of participation. Although an RCO may have both 12-Step and treatment provider members, the relationships that develop within an RCO typically are not sponsor/sponsee or counselor/client in nature. Yet, within an organization that highly values recovery and strives to build caring relationships among its members, there can be a strong need to reach out and help a member who is believed to be at risk of or already in relapse.

How does an RCO do this? This was not the subject of focused discussion during the meeting. It became clear, however, particularly during the Recovery Community Dialogue, that it was a subject of concern for many grantees, requiring further discussion at another meeting.

☛ *Tip*

Double, Triple, or Quadruple Stigmas

Dialogue participants discussed several stigmas that operate in conjunction with the stigma associated with addiction. These additional layers of stigma create further barriers to individuals and communities attempting to address the stigma associated with addiction.

Race. The media portrays addiction as an African American problem or, in Indian country, as part of the "drunken Indian" stereotype. In the case of African Americans, this is compounded by addiction and treatment myths (e.g., crack is more addictive than other drugs and you can't recover if you are addicted to it) and discriminatory public policies (e.g., the disparity in crack and cocaine sentencing).

Gender. A Wisconsin statute labels pregnant women who exhibit "habitual loss of self control" with drugs or alcohol as "child abusers." Use of drugs or alcohol is perceived to negate any possibility of good mothering. Female addicts are also doubly stigmatized because they have stepped outside their socially prescribed roles as "good girls" and their behavior is associated with "promiscuity."

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◗ An aha! moment

"Until this very moment I had not thought about the way we stigmatize ourselves and each other. This may be the central organizing challenge of the recovery community!" — Meeting participant

☛ *Tip*

RCSP ISSUE
Dealing with Internalized Stigma (or Internalized Oppression)

As dialogue participants focused on the ways in which members of the recovery and treatment communities often stigmatize themselves and each other, the organizing challenges faced by RCOs began to take on another dimension. Examples of internalized stigma included:

- The alcoholic who boasts he's never done anything illegal in his life.
- The 12-Step group member who puts down the person in methadone maintenance.
- The treatment program or support group that refuses to entertain any mention of sexual identity issues of a person seeking recovery.
- The suburban parent who doesn't want an addicted child to associate with "inner-city" addicts.
- The tendency to label treatment and recovery vehicles as being for other people (e.g., the Native American who labels AA as a "white man's program").
- The tendency to think that whatever program made you sober is the only "righteous" way.
- The tendency to avoid others in recovery who have double or triple stigmas we don't share (e.g., those who are HIV positive or of another race or ethnicity or different sexual orientation, or have a criminal record).
- The willingness to accept and even use stigmatizing language and labels (substance abuser, drug fiend, crackhead) about ourselves and others in our community.

☛ *Tip*

Building Bridges Within the Recovery Community

Is it enough to simply announce that your recovery community organization is "open and inclusive?" A number of Dialogue participants thought much more effort is required. Examples of early RCSP strategies for building "connectedness" and for finding commonalities, while respecting differences within the recovery community, include:

- The work of several abstinence-based RCOs in reaching out to the methadone maintenance recovery community and developing membership education to help integrate two different recovery cultures.
- The work of a number of RCOs to engineer diversity in their early leadership group reflective of the diversity of the target recovery community.
- Early collaborative efforts among RCSP grantees in which the cultural expertise of some grantees is being exported and shared by others.

◗ GANDHI'S WISDOM

"Gandhi said, 'You must be the change you seek.' This means that in our organizations we need to model the anti-stigma message we want to send." — Meeting participant

☛ *Tip*

BUILDING BRIDGES BEYOND THE RECOVERY COMMUNITY

Other stigma-reduction strategies shared by the participants included:

1. Keep your message focused on the hope and values represented by recovery.
2. Look for projects that permit recovering addicts to demonstrate the power of recovery in a public forum.
   - "In December we decorated an 18-foot 'tree of hope' at the court house. People and families in recovery, people in treatment programs, people who had lost loved ones to addiction, brought handmade ornaments expressing their gratitude and their love. Court officials were astonished. It was awesome!"
   - "Partnering with Habitat for Humanity, recovering alcoholics and addicts, wearing tee-shirts saying 'Ambassadors for Recovery,' we rehabilitated four houses, including a former crack house."
3. Build linkages to other groups, such as faith-based communities, schools, and unions.
   - "We're working within a faith-based coalition. They've had to deal with their stigmas about IV drug users, and we've had to deal with our stigmas about them."
   - "We have found our biggest supporters to be the auto workers' union employee assistance plans. They know the problem, and they know that treatment can be part of the solution. They let us use union halls for meetings. They work with us on everything from advocacy training to sober picnics."
4. Focus on the biology, the science, and the data, and use language carefully.
   - "We need the science. Science lets us look objectively at what exists. But we need the faces, too. The human faces. We need to marry the science and the faces."

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Sexual Orientation. Stigmatization of sexual orientation or gender identities compounds with stigmatization of addiction, and concepts like "aberrant" and "deviant" provide a way to put people outside humanity.

Criminality. By definition, addicts who use illegal drugs have broken the law, and this makes it easy to say that they are bad people. Criminalization of illicit drug use, while alcohol use is legal, leads to odd stigma paradigms – e.g., it is acceptable for a policeman to admit he is an alcoholic and get treatment, but not that he uses illegal drugs.

People without power. It is easier to stigmatize people who have no power. Stigma is intertwined with class, physical, or mental disability, and any other characteristic that makes groups of people vulnerable within existing power hierarchies. An example of this is the coupling of addiction and welfare in the public mind.

■ MEETING REPORT NO. 4

Building Our Recovery Communities:

GRANTEE MEETING AND TRAINING INSTITUTE

Highlights from

COMMUNITY MOBILIZATION INSTITUTE

Facilitated by Judith Bailie (trainer and consultant from Santa Fe, New Mexico) and Jim Hickman (trainer and consultant from Falls Church, Virginia), this Institute focused on building skills and sharing Recovery Community Support Program (RCSP) experience in mobilizing a constituency and extending its depth and its reach.

Topics for sessions included:

- Clarification of terms and definitions related to community mobilization
- Creative incentives for specific populations that will draw and maintain a pool of actively engaged participants

- Study of a design for successful participatory meetings for a broad-based community response
- Sharing of promising practices from the grantees
- Tips for building a successful collaboration
- Identifying stakeholders, gatekeepers, and allies
- Creating a consistent and marketable outreach message
- Assessing the cultural environment of your organization and community.

By focusing on recruitment and retention techniques and skills, this Institute covered the basic skills and knowledge required for mobilizing a community and convening participatory community meetings. Moving beyond the basics, to the broader community systems within which people live and work, the Institute looked at identifying and engaging stakeholders and creating effective partnerships with them.

Much of the work of this Institute involved interactive and experiential exercises that do not lend themselves to summary reporting. The following sections highlight some of the basic concepts that were explored. Many of these concepts also were covered by the Organizational Development Institute, but the Institutes dealt with the concepts differently, each within its own context.

Engagement and Retention

Every voluntary program reaches out through recruitment to find committed members who will make its program a priority. Once potential members are found, it has to make them feel connected and comfortable enough to want to become involved and make the program a priority in their lives. This process is called **mobilization**.

Mobilization is a two-way street. People recruited will expect certain things from the group, such as efforts to resolve the problems they, and others like them, have experienced. They need to be able to trust the group and its leaders. In turn, the program doing the recruitment needs to acknowledge the expertise of the people it is trying to recruit and what they can bring to the organization in the way of skills, energies, interests, and ways of thinking.

☛ *Tip*

Trust and Inclusion: An Introductory Exercise

It takes time to build trust among members, and there must be formal and informal opportunities for people to get to know one another as individuals if the membership is to develop a sense of cohesion. Remember that in the early stages of group development, a key task is for members to resolve questions of personal and group identity: Who is here? Who am I in relation to the others? How will I fit in? What do we have in common? What will be my role in this group?

Early in the Community Mobilization Institute, participants were invited to engage in a group-building activity that helped them to get to know one another on a human level, thereby building a sense of trust, comfort, and belonging. The exercise takes a bit of time, but participants seemed to feel it was worth the investment.

Every member was invited to introduce himself or herself by sharing their responses to the following questions:

1. What is your name? Do you have a nickname?
2. Were you named after anyone?
3. What does your name mean?

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Getting People Involved

Interaction with new members is very important. Informal discussions can be a time of helping new members recognize that the organization has values consistent with their own, and having shared values helps energize members to stay with the large group. Mobilization around shared values can be viewed as a means of making people feel comfortable and valued.

One of the best tools for retaining new recruits is drawing from their expertise in a way that tells them they are valued and that their potential contributions to the organization are recognized. And one means of enabling them to contribute is to listen to them, within the context of their experiences, and respond by letting them know how the organization can both assist them and benefit from having them as members.

If people are being recruited from a different culture than the leaders or most of the members of the RCO, it is important not to assume that they will share all the existing points of view. Differences in styles and cultures must be respected. Cultural synthesis is the goal, rather than attempting to gain universal acceptance of "the correct" views.

Participatory Meetings

Another important means for retaining new members is to conduct participatory meetings in which they can express their opinions and ideas and be listened to.

Have a written agenda for meetings, so people will know what is going to happen. In meetings, stay actively focused on tasks. Remember that some people, who seem inactive, may play an important role of reflecting on what the group has done, often providing important insights. If people are asked to reflect and see others doing so, they will begin to do so without being asked.

◗ **Keeping a Balance**

"In meetings, keep a balance between what you are giving participants and what they are giving you." — Meeting participant

Establishing Guidelines for Meetings

It is important to the group process to establish clear, explicit guidelines for your meetings. It is helpful to use a participatory process in generating the guidelines, which will become the social contract among the members.

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4. What are two important values you learned from your family?
5. What is your cultural background?

After everyone had spoken, the facilitators highlighted differences and commonalities among members and underscored the importance of honoring the diversity among participants.

This exercise can be a powerful way to begin an early membership or board meeting, communicating that people are valued for who they are and what they bring to the organization.

☛ *Tip*

Participatory Meeting Processes

- Start with a shared vision.
- Encourage participation by the silent. (But don't force it.)
- State a topic or ask for suggestions.
- Invite/solicit additional input throughout the meeting.
- Listen to and identify problems.
- Identify desired outcomes.
- Review strengths for goal achievement.
- Develop strategies for action.
- Ask for volunteers to take action.
- Appoint others.
- Define action steps, assignments, time frames.
- Review.

Participatory norm-setting also can be a means of minimizing conflict in groups because everyone has agreed up front to abide by the norms.

Consider inviting the group to brainstorm a list of guidelines in response to the question: What behaviors would help us to have a comfortable, creative, and productive meeting? Examples (which could be shared with members) include the following:

- Only one person speaks at a time.
- Everyone's ideas and opinions have value.
- Be hard on ideas, easy on people.
- Think "outside of the box;" be creative.
- Agree to disagree and move on.
- Stay on task.
- Honor the time schedule.
- Have fun!

Once the group has settled on its list of group norms, ask each person if he or she can agree to the norms and emphasize that everyone — not just the leaders — has a part in ensuring that the members honor the norms.

Importance of Shared Values

The importance of shared values was emphasized in both the Community Mobilization and the Organizational Development Institutes. People join voluntary organizations because they value the objectives of the group. Among other goals, RCOs want to improve opportunities for recovery and overcome stigma. Because these are the primary values around which members can mobilize, it is important to make them explicit.

However, the recovery community is very diverse, and there are differences and disparities among recovery community members. Divisions can occur within the RCO, and sometimes these can splinter your group or cause intragroup conflict. For example, recovering alcoholics may have difficulty relating to recovering heroin addicts, or people who recovered in a therapeutic community may not be empathetic with those who recovered using a day treatment model. People on methadone maintenance may be considered to still be using drugs, rather than as taking a prescribed medication for the treatment of addiction. All the more reason to focus on values shared by all the subgroups—such as the needs of all people

who are addicted, irrespective of modality of treatment, and the prevalence of stigma toward all addicts and alcoholics, regardless of their drug of choice.

◗ ORGANIZATIONAL VALUES

"After learning what individual members value, it is important that members work together to determine what they value as a group, and define what they expect of themselves and each other as components of a functioning unit." — Facilitator

MOTIVATION TO STAY INVOLVED

People participate because they feel motivated, and motivation comes from both tangible and intangible factors. The tangible motivators are not usually considered to be as important as the intangible ones (like those in the accompanying Tip), but they have a place. The tangibles range from the provision of child care or refreshments to literature, logo items such as pins and buttons, pens, bumper stickers, or refrigerator magnets.

IDENTIFYING STAKEHOLDERS, GATEKEEPERS, ALLIES

It takes time to build a community and to identify the roles that people can play within the community. Exercises — such as those used at conferences and meetings in which people describe themselves, their interests, and unusual aspects of their lives — can be very useful in identifying leaders. Watch to see who wants to go first. Usually the first person to volunteer to make an introduction is the person with either the *most* or the *least* power. Watch how people defer to each other. Watch for the community gatekeepers (those familiar with informal and formal systems), the stakeholders (people who have an investment in goals and purposes like those of the RCO), the allies (those who can assist the group, who have ties to other important organizations and systems), and the marketers (members who can help publicize and promote the RCO). When group leaders understand these roles that members can play, and allow members to express themselves by applying their skills, the individual members will feel empowered and the group will be energized.

☛ *Tip*

DON'T FORGET INTANGIBLE MOTIVATORS

Remember the "intangible motivators" that keep members coming back to the RCO—

- Feeling good energy during and after meetings
- Having a sense of accomplishment
- Learning new participatory skills
- Experiencing validation and affirmation
- Being recognized for expressing views
- Having a voice
- Having fun
- Learning new ideas
- Being part of a team
- Experiencing personal growth.

■ MEETING REPORT NO. 5

Building Our Recovery Communities:

GRANTEE MEETING AND TRAINING INSTITUTES

Highlights from

ORGANIZATIONAL DEVELOPMENT INSTITUTE

Facilitated by Elizabeth Burden (trainer and consultant from Tucson, Arizona) and Mark Harris (trainer and consultant from Eugene, Oregon), this Institute† focused on building skills and sharing Recovery Community Support Program (RCSP) experience in building and sustaining a recovery community organization (RCO).

† Much of the information presented on this Institute was adapted from the Center for Substance Abuse Prevention (CSAP) Institute for Partnership Development, available at http://www.prevention.org.

Topics covered included:

- Being mindful of purpose, structure, processes, and climate, what makes a successful organization?
- Building shared vision and purpose.
- Designing structures and processes that work toward your goals.
- Organizations as communities: Creating an open climate.
- Dealing with ups and downs: Preparing for the evolution and revolution as organizations grow.
- From "Mom and Pop" to "shareholders" and beyond: Promoting ownership of the organization.

The Institute started from the premise that organizational processes and structures should be congruent with organizational purposes. A core purpose of most RCOs is to attract and retain recovery community members to participate in improving addiction treatment systems. Here are some of the highlights of the "organizational puzzle" for RCOs seeking to promote recovery community participation:

WHAT ARE THE ELEMENTS OF A SUCCESSFUL ORGANIZATION?

An organization functions in several interrelated dimensions:

- PURPOSES — Values, Vision, and Mission

"Purposes" is shorthand for an organization's values, vision, and mission. While the **mission** of an organization is fairly concrete, consisting of specific goals, objectives, and activities, organizational vision and values zoom to a bigger picture. **Vision** is like a lighthouse, which illuminates, rather than limits, and gives direction, rather than a destination. A vision finishes the sentence: "When we are successful, we will…." (In contrast, a mission comes from the head and tells what needs the organization wants to address and how it will do so.) Vision expresses the organization's **values** – the ideals, convictions, and hopes of the organization.

- STRUCTURE — Levels of formalization, hierarchy, specialization, and centralization

The structure of an organization is reflected in such documents as an organizational chart, a statement of policies and procedures, operating guidelines for committees or other small groups, and definitions of the roles and responsibilities of the members, board, and staff.

No structure is inherently good or bad. A very traditional structure can be nurturing and participatory. The structure of an organization should be in a form appropriate to the group's expectations as reflected in its values, vision, mission, and principles and should be transparent to the group.

◗ FORM FOLLOWS SUBSTANCE

"Our bylaws state that our values, goals, and strategies should reflect the consensus of voting members (consumer and families); that it is the responsibility of the Board to provide opportunities for a consensus to develop and to nurture communication and feedback between the members and the Board. Consumers and families insisted on this when the bylaws were written." — Meeting participant

- PRACTICES — Key methods of interaction among board, staff, and members

Key practices include the methods used by leaders, methods of communication, planning processes, decision-making processes, the use of power, developmental processes, and allocation of resources.

- CLIMATE — How the practices are carried out

Climate is determined by the "degree of openness or closedness," and the degree to which members and volunteers are invited to participate in and influence decision-making. Like the weather, organizational climate is the sum of "prevailing conditions," including accessibility, receptiveness to new ideas, freedom from bias, candor, and effective dialogue. The prevailing conditions determine how people behave. Prevailing conditions are influenced by organizational structure, decision-making mechanisms, and communication practices.

- CULTURE — The mixture of details that give the organization its identity

Details include behaviors, attitudes, feelings of trust, respect, and honesty. Do people feel free to take part in dialogue, give input, and participate fully in the work of the organization? Or are people afraid they will be ignored or criticized if they speak their mind? Is member enthusiasm seen as a strength or a nuisance? Is talent recognized? Is creativity recognized? Does the organization respect itself?

How does an RCO design structures and processes that work toward its goals and promote participation?

- Support for shared values

☛ *Tip*

BARRIERS TO OPENNESS

- Distrust
- Fear, intimidation
- Disrespect
- Unresolved conflict
- Sense of powerlessness
- Not listening
- Emphasis on status
- Feelings of oppression (e.g., racism, classism, sexism, heterosexism)

A participatory organization rests on clearly defined organizational values, perhaps originally defined by its founders but constantly refined by its members.

◗ ON VALUES

"RCOs have to be value-based, because recovery is value-based. That's what we have in common, no matter how else we are diverse. Maybe it's hard to figure out what those common values are, between abstinence-based and methadone maintenance recovery, for example, or between a recovering CEO and a recovering homeless person, but it's those common values that we need to identify and work from." — Meeting participant

Typical core values of participatory organizations include:

- Individual and group relationships based on trust,
- Individual and group empowerment,
- Emphasis on ongoing dialogue, and
- Respect for differences and diversity of the group's members.

The leaders of participatory organizations reflect and practice the organization's values. As a participatory organization evolves, especially if it is inclusive and begins both to inform and integrate the perspectives of its participants, its values may evolve as well.

◗ RECOVERY VALUES

"My personal recovery is all about accepting Jesus Christ as my personal savior. Only then was I able to get my life back in order. It's a step for me to think that there are other recovery values — personally I don't need any others. But I'm thinking about what addicts who aren't yet 'born again' might need to get started." — Meeting participant

"For those of us who live in Indian Country, there may be core recovery values, but at least as important are core cultural values. One thing we like about the RCSP is that it gives us space to think about this without forcing us into some homogenized recovery community." — Meeting participant

"At the core of who I am is my sexual identity, and all my values derive from my struggles to acknowledge and make others acknowledge that. I'm also in recovery, and those values are important to me, too. But I know sexual identity was important to my addiction and is integral to my recovery, and that current treatment and support structures are often not responsive." — Meeting participant

"Many 12-Step-based treatment programs, including mine, are abstinence-based, but recognize that 'progress, not perfection' is the reality of addiction. Methadone maintenance scares us — but maybe 'getting better,' rather than getting perfect, is what counts." — Meeting participant

If the values that RCO members consider important are given room to grow, and are clearly articulated and understood, developing a vision for the organization, (and all other decision-making and problem-solving) will be easier.

- Support for shared vision

To create a shared vision of a participatory organization, it is important to do at least five things:

- Abandon the idea that vision comes only from the top and is passed down to members.
- Generate opportunities to create and share individual vision.
- Listen to others' ideas about their vision.
- Recognize that some members may not accept every detail of the vision, but that this is okay.
- Ensure that the group has not created an unachievable vision that ensures failure.

Organizing people around vision and values allows the RCO to address specific concerns effectively.

◗ **On vision**

"Without vision, RCOs cannot inspire members to transform their communities. Without vision, RCOs will remain the prisoners of failed paradigms." — Meeting participant

The group's vision will emerge when members are asked to address the following:

- Problems they experience in obtaining treatment and during treatment.
- Problems they are experiencing in recovery, e.g., seeking employment, finding child care, finding job training opportunities, gaining acceptance in the community.
- What treatment and recovery would be like if these problems were addressed.
- What changes the group can address, e.g., forming active alumni groups, informing the public about addiction as a disease rather than a moral problem.
- What the community should know and do about addiction, treatment, and recovery.

☛ *Tip*

A Shared Vision

- Defines what it is we want to create.
- Establishes our overarching goal.
- Uplifts aspirations.
- Creates a common identity.
- Compels courage.
- Fosters risk-taking.
- Promotes ownership.
- Keeps members moving.
- Encourages commitment.
- Keeps up the spirit.

☛ *Tip*

Vision and Energy

Working to develop and maintain a shared vision helps maintain the energy of members and enhances the spirit of the organization. Energy and spirit are hard to define, but it is clear when an organization has lost them because the focus on values — and the value of its work — is lost as well.

Sometimes, an organization may have a negative vision, focusing on what people don't want or are avoiding. A negative vision is limiting and conveys a sense of powerlessness, something an RCO wants to avoid.

☛ *Tip*

VISION: NOT FOR THE DEEP FREEZE

RCO vision needs to be referenced constantly, and commitment to it reinforced. A vision can die if newcomers do not understand or "buy in" to it. Or if diversity becomes a divisive force. Or if alternative views are treated with disrespect, or new ideas rejected out of hand. Or if, as members become more involved, the vision begins to appear outmoded or irrelevant to their willingness to invest their time and energy. Or if the inevitable demands of reality and compromise create a gap that members cannot understand between organizational action (or inaction) and their vision for the future. Enhancing and reinforcing the vision should be a continuing RCO goal.

Depending on the style of the organization, members can craft a vision statement themselves, or may review a draft done by staff or other leadership. It is important, however, that a vision reflect input given by members and that they do not view the process as something "over their heads" and not their concern.

- Clarity of mission

The goals and objectives of an organization's mission may change over time as a participatory RCO begins to develop its collective values and vision, or as circumstances change. For example, a group may originally have the goal of educating the community about the value and effectiveness of treatment. As members realize the proportions of the local problem of heroin overdose, they may choose to focus on this particular issue. But providing information about the possibility of overdose and the importance of intervention can be seen as part of the overall message to the community. Or, an original goal might have been to build the recovery community around alumni groups at treatment centers. When the RCO discovers that the alumni groups are not as strong as originally believed, it might change its goal from "organize around alumni groups" to "help alumni groups become established."

Members need to be involved in making such essential changes in vision. If members are uncertain or disagree about specific changes, or if staff or other current leadership want to avoid being perceived as controlling or directive, it may help to bring in an outside facilitator to ensure participatory decision-making.

SHARING POWER AND RESOURCES

As RCSP projects mature from a grant proposal to an implemented project, one of the most difficult challenges is how to share resources and power to benefit the RCO and its members and to achieve the goals of the RCSP. Resources and sources of power include information, energy, skills, leadership, spiritual power (which can motivate, strengthen, and guide individuals), enthusiasm, and money.

Who, for example, goes to what RCSP meetings? Who receives what RCSP communications?

◗ **WHO'S HERE?**

"I don't want anybody here to feel bad, but don't you have to ask who gets to come to the meetings in Washington? Who's on the circulation list for the TA Tips? Who's involved in designing and then vetting your case study?" — Plenary panelist

How can an organization deepen its members' understanding of how systems work and the levers for change? Some levers for change include providing education to put a face on recovery, conducting an organized action, or informing employers about the capabilities of people in recovery.

◗ On deepening understanding

"Members' training is at the heart of our project. Maybe that's a didactic word, but the point is that our constituency has to catch up on a lot — both skills and information — before it can go to the table and hold its own." — Meeting participant

What is the right mix of hierarchical decision-making and responsibility based on knowledge, skills, and experience, on the one hand, and decision-making and responsibility based on participatory processes, on the other?

◗ On functional hierarchy

"Building everything on consensus can be great. Or it can be anarchy. We need a functional hierarchy, to fill our commitment, to organize. We cannot throw away responsibility in the attempt to empower others." — Meeting participant

Is what seems right today necessarily what seemed right yesterday? Will it seem right tomorrow? How will we know?

Encouraging participation

Participation can be encouraged by recruiting members who combine seriousness with enthusiasm about the purposes of the organization. Key to this are the understanding and enthusiasm of the recruiter. A good recruitment strategy will make sure that the recruiters (including gatekeepers and mentors for newcomers) are informed about and engaged in the organization's values, vision, and mission and are able to convey this information accurately and with passion.

Also key is giving roles and responsibilities to members — roles and responsibilities that they are excited about assuming. This can be encouraged by expressing confidence in members, routinely soliciting their views, routinely sharing information in a user-friendly format, demonstrating a willingness to help members acquire new skills, and respecting their opinions. Also important are readily sharing information and encouraging members to contribute to decision-making processes.

◗ On empowerment

"Sometimes people in recovery, especially early recovery, have been outside the system for so long that they believe they have nothing to contribute inside the system. One of our challenges is reversing that belief." — Meeting participant

☛ *Tip*

VALUES SUPPORTING DIALOGUE

Renowned educator Paulo Freire, an inspiration for one RCSP grantee, has written about dialogue in terms of values:

- Dialogue cannot exist in the absence of a profound love for the world and for people.
- Dialogue cannot exist without humility.
- Dialogue is not an act of arrogance.
- Dialogue requires intense faith.
- Dialogue cannot exist without hope.
- Dialogue only occurs when participants are willing to question, and even doubt, themselves.

☛ *Tip*

OWNERSHIP SURVEY

Ownership means different things to different people. Although the group may need to come to a shared definition of ownership, there are common indicators. Some groups regularly survey their membership to assess whether a sense of ownership is the norm. Questions that can be asked include:

- Who are the "owners" of our organization?
- If we increase the owners, who will lose what?

(continued on next page)

ENCOURAGING DIALOGUE

In a dialogue, everyone has something to contribute. One person's ideas build on those of others and contribute to the creation of something new. Suspending assumptions is an essential part of dialogue. In turn, dialogue is an essential process for an open climate. In dialogue, people look at complex issues from many points of view, communicate their views, and explore their assumptions freely. Leaders foster a spirit of inquiry, asking questions that help members explore the thinking behind their views, the assumptions held, and the evidence that leads to those views.

Dialogue is different from advocacy and it takes practice.

Dialogue requires intelligent and **responsive listening,** which in turn calls for:

- Concentrating on the information and the emotion being expressed,
- Listening in context and keeping an open mind, and
- Responding to what we heard, as opposed to saying what we were prepared to say.

An intelligent and responsive listener needs to be able to hold an idea for later in a dialogue or respond to what has been said by giving feedback: clarifying, restating, paraphrasing, reflecting, or summarizing and asking supportive questions.

◗ RECOVERY COMMUNITY LISTENING

"Everyone says that people in recovery know about telling their stories. But we also know how to listen to people's stories and, more important, how to learn from them. This isn't such an easy thing for most people, and it gives us a leg up." — Meeting participant

Why is ownership important? What does it mean? How is it fostered as an organization evolves?

At the heart of sustaining a participatory organization is a sense of "ownership" of the organization by the participants. Central to this sense of ownership is that the participants feel needed by the organization, and that it benefits from their contributions. Building a sense of ownership takes time and patience, and is one of the critical tasks of leadership.

Just as recovery has "ups and downs," so will an RCO. "Downs" are a normal part of life and are survived by healthy individuals and healthy organizations. Indeed, a "down" can be the occasion for reaffirmation and/or clarification of goals, development of new skills, or emergence of strengthened leadership.

For example, an RCO may initially experience a period of growth characterized by creativity, enthusiasm for a shared vision, and excitement about changing public

attitudes. Then, a crisis occurs. Perhaps there is a leadership crisis, and the project director resigns. The vision may suddenly seem blurred and even contentious. There may even be an initial tendency to focus on apportioning blame. But, in an organization where participants feel a sense of ownership, people begin to solve problems in order to preserve an organization that they value. Members may assume responsibility for helping to find a new director. Leaders, both on the staff and among the members, may begin to play new roles.

◗ **On finding a new project director**

"Our project needs to find a new project director. It's comforting to learn that we are not the only project that has faced this, and that our doubts and fears are not only normal, but give us an opportunity to grow the organization through the process." — Meeting participant

New leaders may begin to emerge as people discover skills they didn't realize they had. Through this process, the direction of the organization may become clearer, and the commitment of the participants be enhanced.

Crises such as these may at first appear to be challenges to the participants' sense of ownership in the organization as informal decision-making processes give way to more formalized structures. For example, participants may begin to feel less and less involved in decision-making and to believe that the organization belongs to those who set the rules. If the process of regeneration is participatory, however, the sense of ownership begins to increase again, and may even emerge stronger than it was before. Viewed from this perspective, the "cycle of ownership" — crisis and regeneration — offers RCOs continuous opportunities to revisit and, where necessary, revitalize the common commitment to shared values, vision, and mission that are the key to its success.

(continued)

- What will actually change if we meet the needs of the new owners?
- What will be the reactions of the current owners?
- What do current owners and new owners need in order to adjust to their new roles?
- How can we treat current owners with respect for the past efforts, and sill move toward opening access to ownership?

☛ *Tip*

Crisis and Regeneration

Crises may occur, followed by periods of regeneration, throughout the life of the organization. Typical patterns include:

- *Crisis of autonomy*
  Followed by growth as the organization learns to delegate
- *Crisis of control*
  Followed by growth as the bureaucratic structure keeps things going
- *Crisis of red tape*
  Followed by growth through establishing simpler procedures
- *Crisis of wasted time*
  Followed by growth through refocusing on goals

■ APPENDIX I

Case Study Guidelines

RECOVERY COMMUNITY SUPPORT PROGRAM

1. Executive Summary

2. The Target Community

A. Define and briefly describe the target community. Your description should include information relevant to your project, such as demographic information, and a discussion of the leadership of the target community or particular issues or obstacles faced by the target community.

B. Give as much information about the community(ies) that include or affect the target community as you think is relevant to give a context for your project.

C. To define the target community, did you have to resolve any issues? If so, please describe the issues, and include an explanation of both the rationale and the process for the resolution.

D. Did your project's definition of the target community change during the course of your project? If so, please explain both the rationale and the process for the change.

3. Mission, Goals/Objectives, and Measures of Success

A. What was the mission and what were the goals and objectives of your project as it was originally conceived? Did you identify a way to measure whether the project had succeeded in meetings its goals and objectives? If so, describe.

B. Describe (if appropriate) the manner (including both rationale and process) by which your project's mission and/or goals and objectives, or its measures of success, changed over the life of the project. How did your thinking change as a result?

C. If you identified (either at inception or as your project proceeded) measures of success for your project, please describe them, including the strengths and weaknesses of those measures as you perceive them.

4. Project Activities

To advance the GFA goal of advancing understanding in the field, it is critical that **all** of the case studies **at a minimum** review project activities in the three basic areas identified below. **Your case study may, of course, cover additional areas as well.**

A. Describe your project's approaches to engaging and retaining the recovery community in project activities. This should include discussion of outreach strategies and activities, obstacles encountered and how they were resolved, what worked and what didn't, and membership trends among different populations. It should also include a discussion of your project's efforts to keep members of the recovery community involved, again including what worked and what didn't.

B. Describe the organizational development of your project. This should include, at a minimum, a discussion of the nature of the grantee organization, your plans (if any) at the outset with respect to establishing a recovery community organization independent of the grantee organization, and the evolution of those plans over the life of the grant, including any modifications to the plans and obstacles and strategies used to attempt to overcome them. This should also include a discussion of how your project was organized to encourage participation, empowerment, and leadership.

C. What financial support was developed and secured to assure continuation of your project beyond the three-year grant period?

5. Outcomes/Impacts/Changes/Successes

A. What outcomes did you anticipate at the outset?

B. Describe (if appropriate) the manner (including both rationale and process) in which the outcomes you sought changed over the life of the project.

C. Did you achieve the outcomes you sought and how do you know?

6. Lessons Learned

A. What do you think are the most important lessons to be learned from your project?

B. If you had your project to do over again, what would you do differently?

C. As you look ahead to your project's continuation, what do you anticipate doing differently?

D. In the course of the project, what did you encounter that was unexpected?

Appendices

- A brief chronology of important milestones in the life of your project. This should include important steps and events, and should identify times that you feel were critical turning points or decision-making points for your project.
- A list of products (such as surveys, curricula, or other materials developed by grantees) attached to the case study as exhibits.

■ APPENDIX II

Meeting and Institutes Agenda

JUNE 28 - JULY 1, 1999

MONDAY, JUNE 28, 1999

TIME	EVENT
11:30 a.m. - 1:00 p.m.	**Registration**
1:00 p.m. - 5:00 p.m.	**Opening Plenary Session**
1:00 p.m. - 1:15 p.m.	**Welcome:** Rick Sampson, *Director* *Division of State and Community Assistance (DSCA)* *Center for Substance Abuse Treatment (CSAT)* *Substance Abuse and Mental Health Services Administration (SAMHSA)* *Rockville, Maryland*

1:15 p.m. - 1:30 p.m. **Introductions and Overview**

Catherine D. Nugent, *Project Officer*
Recovery Community Support Program (RCSP)
CSAT

1:30 p.m. - 2:40 p.m. **Panel Presentation: Borrowed Foundations and New Structures**

MODERATOR:

Rick Sampson, *CSAT*

PANELISTS:

Larry D. Belcher, *Chief Executive Officer*
West Virginia Mental Health Consumers Association
Director, Consumer Organization and Networking Technical Assistance Center
Charleston, West Virginia

Myra Hill, *Co-Chair*
State of Maryland HIV Prevention Community Planning Group
Baltimore, Maryland

Anthony Tusler, *High Tech Coordinator*
Disability Resources Department
Santa Rosa Junior College
Santa Rosa, California

2:30 p.m. - 3:20 p.m. **Discussion**

FACILITATORS:

Elizabeth Burden
Burden and Burden Consultancy
Tucson, Arizona

Catherine D. Nugent, *CSAT*

3:45 p.m. - 5:30 p.m. **Team Time 1**

FACILITATOR:

Judith Bailie
Bailie and Associates
Santa Fe, New Mexico

- 1446 Contra Costa County Partners in Recovery Alliance (PIRA)
- 1463 Lesbian and Gay Community Services Center
- 1451 Pima Prevention Partnership

•1467 White Bison

•1452 Winnebago Service Area Healthy Start

FACILITATOR:

Elizabeth Burden

•1449 Central City Concern

•1455 Dallas Helps

•1437 El Paso Alliance

•1444 Missouri State Department of Mental Health

FACILITATOR:

Mark Harris, *Eugene, Oregon*

•1453 California Association of Alcohol and Drug Program Executives

•1462 National Council on Alcoholism and Drug Dependence of Michigan

•1461 Recovery Communities United of Chicago

•1643 Santa Barbara Recovery Community Network

•1456 University of Wisconsin - Madison

FACILITATOR:

James Hickman, *Falls Church, Virginia*

•1641 Bucks County Council on Alcoholism and Drug Dependence

•1450 Connecticut Community for Addiction Recovery (CCAR)

•1642 New England Alliance for Addiction Recovery (NEAAR)

•1460 Pennsylvania Recovery Organizations Alliance (Pro-A)

•1469 Substance Abuse and Addiction Recovery Alliance (SAARA)

6:00 p.m. - 7:30 p.m. **Networking and Resources-Sharing Session**

FACILITATOR:

Elizabeth Burden

7:30 p.m. - 8:30 p.m. **AA**

NA

Al-Anon

TUESDAY, JUNE 29, 1999

8:30 a.m.-12:00 p.m. **Training Institute/Dialogue Session 1**

A. Organizational Development
Building an organization that nurtures volunteers, members, and staff as they define a shared vision and work to achieve mission and goals

INSTITUTE LEADERS:
Elizabeth Burden and Mark Harris

B. Community Development
Building skills in recruitment, retention, and convening participatory meetings

INSTITUTE LEADERS:
Judith Bailie and James Hickman

C. Recovery Community Dialogue
Discussing power, powerlessness, and empowerment from a recovery perspective and integrating these concepts into RCSP organizational development and community mobilization efforts

DIALOGUE FACILITATOR:
Billie Alexander Avery
Pengram, Tennessee

1:30 p.m. - 3:15 p.m. **Team Time 2**

FACILITATORS:
Judith Bailie, Elizabeth Burden, Mark Harris and James Hickman

3:45 p.m. - 4:45 p.m. **Plenary Session**

Keynote Address: Building Community

Terry Tafoya, *Executive Director*
Tamanawit Unlimited
Seattle, Washington

4:45 p.m .- 5:00 p.m. **Community Meeting**

FACILITATOR:
Elizabeth Burden

5:30 p.m. - 6:30 p.m. **AA**

NA

Al-Anon

7:00 p.m. - 8:30 p.m.

Optional Evening Events

Invitational Focus Group:
Customizing SAMHSA's Managed Care Materials for the Recovery Community

FACILITATORS:

June Gertig, *Project Director*
RCSP Technical Assistance Project
Health Systems Research, Inc.
Washington, D.C.

Chris Heldman, *Public Health Analyst*
Office of Managed Care, SAMHSA
Rockville, Maryland

Optional Discussion Session:
An Update on Federal and State Parity Issuses

DISCUSSION LEADER:

Kenneth Libertoff, *Executive Director*
Vermont Association for Mental Health
Burlington, Vermont

WEDNESDAY, JUNE 30, 1999

8:30 a.m. - 12:00 p.m.

Training Institute/Dialogue Session 2

A. Organizational Development
Sustaining an organization — with a sense of community ownership — that attracts and retains people who are committed and involved

INSTITUTE LEADERS:

Elizabeth Burden and Mark Harris

B. Community Development
Assessing cultural environments, developing messages, identifying and engaging key stakeholders, and creating more effective partnerships

INSTITUTE LEADERS:

Judith Bailie and James Hickman

C. Recovery Community Dialogue
Exploring anonymity and stigma and their relationship to RCSP organizational development and community mobilization efforts

Dialogue Facilitator:

Billie Alexander Avery

1:30 p.m. - 3:00 p.m. **Team Time 3**

3:30 p.m. - 4:30 p.m. **Plenary Discussion:**
Themes and Challenges Revisitied

Facilitators:

Elizabeth Burden

Catherine D. Nugent

4:30 p.m. - 5:00 p.m. **CSAT's Consumer/Family-Oriented Initiatives**

H. Westley Clark, *M.D., J.D., M.P.H., CAS, FASAM, Director*
CSAT

Introduced by:

David Griffith, *Chief*
Performance Partnership Grants Program Branch
CSAT, DSCA

5:00 p.m. - 5:15 p.m. **Community Meeting**

Facilitator:

Elizabeth Burden

5:30 p.m. - 6:30 p.m. **AA**

NA

Al-Anon

7:00 p.m. - 9:00 p.m. **SPECIAL EVENING EVENT**
A Call for Grantee Comment on the CSAT National Treatment Action Plan

Moderator:

Johnny Allem, *Acting Deputy Commissioner*
Commission on Mental Health Services
Washington, D.C.

Expert Witnesses:

H. Westley Clark, *M.D., J.D., M.P.H., CAS, FASAM, Director*
CSAT

Camille Barry, *Deputy Director*
CSAT

Rick Sampson, *Director*
CSAT, DSCA

Susan Thau, *Vice President for Policy and Legislation*
Community Anti-Drug Coalitions of America
Alexandria, Virginia

THURSDAY, JULY 1, 1999

8:30 a.m. - 8:45 a.m. **Overview: Case Study Guidelines**

MODERATOR:

W. Barry Blandford, *Project Officer*
CSAT, DSCA, RCSP

8:45 a.m. - 9:45 a.m. **Presentation on Case Study Guidelines (Discussion Draft) and Consensus-Building Discussion with Resource Panel**

PRESENTER:

June Gertig, *RCSP Technical Assistance Project*

FACILITATOR:

Michael Cannon, *Senior Analyst*
COSMOS Corporation
Bethesda, Maryland

PANELISTS:

Alex Brumbaugh, *Project Director*
Santa Barbara Recovery Community Network
Santa Barbara, California

Rick Sampson, *CSAT*

Sara-Ann Steber, *Director*
Technical Assistance and Education Center
University of Pennsylvania
Philadelphia, Pennsylvania

Robert Yin, *President*
COSMOS Corporation
Bethesda, Maryland

10:00 a.m. - 10:30 a.m.	**Case Study Guidelines and Discussion with Resource Panel** *(continued)*
10:30 a.m. - 11:30 a.m.	**Legal and Ethical Issues for the RCSP** Rick Sampson, *CSAT*
11:30 a.m. - 12:15 p.m.	**Plenary Presentation** Mark Lundholm, *Comedian and Motivational Speaker* *Insanity, Inc.* *San Jose, California*
12:15 p.m. - 12:25 p.m.	**Final Remarks** Camille Barry, *Deputy Director* *CSAT*
12:25 p.m. - 12:45 p.m.	**Next Steps and Technical Assistance Resources** Catherine D. Nugent, *CSAT*
12:45 p.m. - 1:00 p.m.	**Closing Circle** Don Coyhis, *Executive Director* *White Bison, Inc.* *Colorado Springs, Colorado*