

from wearing that thing?" At the same time, she has received considerable support from colleagues and friends. "As much as I've faced ignorance and insensitivity in Connecticut, I've also met people who are worldly, intelligent and sensitive." Mona proclaims her love for the U.S., especially for the opportunity she has for knowledge and intellectual stimulation and for the wonderful relationships she has made.

All her family members have moved to the U.S., her father having been the first of the family to settle back in the U.S. Her younger sister completed medical school in Cairo and is in her medical residency in New Jersey. Their proximity to her is crucial because "my family is the most important thing in the world to me."

Now in the second year of her postdoctoral fellowship, she is planning for a career that would blend academia ("I love to teach," currently doing so as an Adjunct Professor at the University of New Haven community psychology program) and direct service, for example, providing cultural sensitivity trainings for professionals working with Muslim or Arab clients. She hopes to make a contribution to psychology by, first, bringing another international perspective into American community psychology in terms of other cultures and second, intervening with now under-resourced Muslim and Arab communities in the U.S. and encouraging others to do the same. She notes that the U.S. mental health system is not responsive to religious needs, so she consults with groups and organizations on integrating religion and mental health. "For example, there are few measures for Arabs' mental health and, up to now, the literature has been either absent or abysmal." She is one of the founders and associate editor of a new publication, the *Journal of Muslim Mental Health*. She was quoted in a *USA Today* story as saying, "Americans don't understand that Muslims have the same anxieties and anguish about terrorism as everyone else in the U.S. At the same time, they're being blamed for it. They're carrying a double burden." Long ago, when researching graduate programs in psychology, she found only one Muslim Arab student. Although she often felt alone as a Muslim- and Arab-American community psychologist, this is changing with the addition of several new colleagues from similar backgrounds.

The American Psychological Association recognized her leadership (as "a dedicated clinical researcher, a compassionate practitioner, and a force for change in mental health service for Muslim and Arab Americans") with the 2006 APA/APAGS Award for Distinguished Graduate Student in Professional Psychology. Check Mona's website for updated information on her work: <http://www.yale.edu/prch/people/amer.html> □

## PREVENTION & PROMOTION—

*Edited by Monica Adams & Derek Griffith*

### **Bridging and Transitioning: The Role of Communities in Promoting Sustainable Recovery from Substance Abuse**

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Relapse rates following acute treatment for substance use disorders are substantial. This is especially true for clients with high problem severity and chronicity, high rates of co-occurring problems, and low family and social supports (McLellan, Lewis, O'Brien, & Kleber, 2000). Approximately 64% of persons entering publicly-funded treatment in the United States have already had one or more prior treatment episodes: 22% with 3-4 prior treatments and 19% with 5 or more prior treatments (Office of Applied Studies [OAS], 2005). Similarly, it is estimated that between 25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year and 50% will be readmitted within 2-5 years (Humphreys, Moos, & Cohen, 1997).

Within the field of addictions treatment and research, there is a growing awareness of the need to actively promote continuing care for recovering substance users following initial substance use disorder treatment. The literature in this area has clearly established a link between participation in aftercare and enhanced treatment outcomes. The duration of continuing care, support group involvement, and participation in outpatient therapy all appear to contribute to improved long-term treatment outcomes; the largest treatment effects are seen among clients who participate in aftercare for at least twelve months (Ritsher, Moos, & Finney, 2002).

Unfortunately, our current addictions treatment system was not designed to manage what we now understand to be a chronic disorder; instead, it supports the delivery of acute interventions which are time-limited and episode-focused, with minimal opportunities for continuing care post-discharge. As a result, most clients do not begin or remain in continuing care. It is estimated that only 1 in 5 clients participate in any form of aftercare following primary treatment (Ito & Donovan, 1986), and strategies shown to increase continuing care participation (e.g., the use of a brief orientation session on continuing care, behavioral contracting, telephone prompts) are not mainstream practices in addiction treatment (Donovan, 1998). Sadly, for many individuals, sustainable recovery cannot be achieved in the short span of time that treat with the result that a substantial percentage of

individuals experience relapse and repeated admissions to acute treatment (OAS, 2005).

Alternative models of sustained recovery management that promote participation in continuing care are urgently needed. Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months, and even years following treatment. Data reveals that durability of recovery from alcoholism—the point at which risk of future lifetime relapse drops below 15%—is not reached until after 4-5 years of sustained remission (De Soto, O'Donnell, & De Soto, 1989). The recovery durability point is even longer for narcotic addiction (Humphreys, Moos, & Cohen, 1997).

Moreover, from the perspective of community psychology, this continuing care must be nested within the natural environments in which people live out their lives. Clients with severe substance use problems are deeply enmeshed in cultures of addiction, an entrenched pattern of daily rituals and social relationships that sustain their addiction. The frailty of post-treatment adjustment is in part due to the resurging siren call of these rituals and relationships (White, Boyle, & Loveland, 2004). Re-exposure to risks in the post-treatment environment (e.g., high availability of substances, interpersonal conflict, poorly structured time, unsupportive friends and family) constitutes one of the largest contributors to relapse following substance use treatment. While the effects of acute treatment erode rapidly over time, more proximal influences in an individual's environment become increasingly salient. Put bluntly, representatives from the culture of addiction conduct aggressive post-treatment monitoring and re-intervention with individuals who have completed treatment, while treatment providers do not. Given the interdependent relationships that exist between individuals and their communities, the importance of anchoring and strengthening recovery within the context of a larger community of recovering people cannot be overstated. Making the transition back into the community is a vital step in fully transferring what has been learned in treatment to one's daily life. In this regard, a new paradigm of addiction treatment is needed, one which places equal emphasis on both the acute intervention phase and subsequent linkage with post-treatment support services in the individual's community.

### Communities of Recovery

Individuals with alcohol and other drug problems have banded together, formally or informally, for mutual support in recovery for more than 250 years (White, Boyle, & Loveland, 2004). One of the oldest such communities of recovery is Alcoholics Anonymous (AA), a fellowship of men and women who meet in small groups around the world to provide mutual aid in sober living efforts (Alcoholics Anonymous, 1982). AA, due to its large membership, geographical dispersion, wide adaptation to other problems, and organiza-

tional longevity has established itself as the standard by which other recovery mutual aid groups are evaluated (White et al., 2004). Participation in recovery support groups has been shown to enhance long-term treatment outcomes overall (Humphreys, 2004), and completion of addiction treatment with recovery group involvement is more predictive of sustained recovery than engaging in either one alone (Nealon-Woods, Ferrari, & Jason, 1995). Unfortunately, without ancillary support, there is high attrition among those discharged from treatment (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). Overall dropout rates in AA range between 35-68%, with most of this attrition occurring in the first weeks and months of contact with AA (Moos & Moos, 2005). Two recent studies of attrition in AA participation during the year following discharge from treatment reported 41% and 40% dropout rates (Humphreys, 2004).

Though most of our knowledge about communities of recovery comes from data on AA, there is also a growing body of evidence supporting sober living communities. One such community is the Oxford House Group, a network of drug-free, residential settings where individuals can live among recovering peers, thus maximizing their access to mutual support as they work to develop long-term sobriety skills. Sober living communities have been shown to dramatically enhance long-term recovery outcomes, particularly for clients with high problem severity and low recovery capital. A recent study compared the post-treatment recovery of individuals discharged from addiction treatment who were randomly assigned to either an Oxford House (one of the 1,200 Oxford Houses in the U.S.) or to traditional post-treatment "aftercare" (access to outpatient continuing care groups). The Oxford House members had less than half the rate of substance use, twice the monthly income, and a third of the incarceration rate of those assigned to traditional aftercare. This is consistent with previous research on the importance of social support in the recovery process and suggests the need for greater linkage between addiction treatment institutions and the growing network of sober housing resources and sober social communities (Jason, Davis, Ferrari, & Bishop, 2001).

### A Bridging and Transitioning Approach to Sustained Recovery

In light of the positive effects that communities of recovery seem to have on treatment outcomes, sustainable recovery may depend to a great extent on our ability to actively link clients to indigenous systems of support beginning at the point of discharge from primary treatment. This is the idea behind the "bridging and transitioning" model of recovery management. The "bridging and transitioning" approach provides acute detoxification and stabilization, but these services are nested within a larger and more sustained continuum of pre-treatment, in-treatment, and post-treatment recovery support services. "Bridging

and transitioning” extends the duration of post-treatment support services, intensifies these services during windows of initial and subsequent vulnerability, and moves the focus of recovery support from the treatment environment to the natural environment of the individual. From a clinical perspective, the process of bridging and transitioning involves sustained and assertive monitoring and feedback; peer-delivered recovery education and coaching; ongoing linkage to indigenous systems of support; enrichment of the post-treatment recovery environment (family, social network, school/workplace, and community); and, when necessary, early re-intervention to minimize the harm from relapse and to re-initiate the recovery process (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). From the client’s perspective, “bridging and transitioning” serves to increase awareness of the sobriety benefits associated with continuing care, and facilitates linkage to communities of recovery following discharge from primary treatment (White & Hagen, 2005).

vironments offer the individual a safe setting in which to apply newly acquired skills and behaviors among peers who can challenge old behaviors and offer positive reinforcement for the new lifestyle sought. Communities can act as an important buffer at this critical juncture of recovery, allowing the recovering addict to focus on the development of long-term sobriety skills and reunification with family and society. For this reason, it is paramount that community and clinical systems remain closely connected throughout the reengagement process.

### **Bridging and Transitioning in Action**

The first wave of “bridging and transitioning” interventions has already arrived, with the emergence of Peer-Based Recovery Support Services (P-BRSS). P-BRSS are offered on a paid or volunteer basis, with the objective of providing assistance to individuals and families attempting to transition into a recovery-based lifestyle following severe alcohol and other drug problems. Providers of P-BRSS may refer to themselves as recovery coaches, peer assistants, recovery mentors, or recovery support specialists. All providers offer normative guidance on the recovery experience (stage-appropriate recovery education), linkage to communities of recovery, consultation on problems encountered in early recovery, on-going monitoring of recovery stability, assistance with lifestyle reconstruction (e.g., sober housing, sober leisure, etc.), and, when needed, a point of early re-intervention into lapses or relapses. (White, Boyle, & Loveland, 2004).

There are many models of organizing P-BRSS. One innovative model for delivery of peer-based recovery support services is exemplified by the Recovery Community Center (RCC), developed by the Connecticut Community of Addiction Recovery (CCAR), which describes its RCC as follows:

A Recovery Community Center (RCC) is a recovery-oriented sanctuary anchored in the heart of the community. It exists (1) to put a face on addiction recovery, (2) to build ‘recovery capital’ in individuals, families and communities and (3) to serve as a physical location where CCAR can organize the local recovery community’s ability to care. (CCAR, 2006)

The RCC moves recovery from “the church basements to main street,” providing a venue for sober socializing, a physical place for recovery development (i.e., linkage to recovery-conducive employment, recovery homes, recovery workshops, planned leisure activities, community service work), and acts as a medium for connecting people with recovery needs to people with recovery assets. CCAR views its RCC as an organizational/human bridge between the professional treatment community and the recovery community. Whereas addiction counselors and Twelve Step sponsors view their service focus in terms of individuals/families that have sought their help, the RCC defines its “client” as the community.

‘Bridging and transitioning’ extends the duration of post-treatment support services, intensifies these services during windows of initial and subsequent vulnerability, and moves the focus of recovery support from the treatment environment to the natural environment of the individual.

The active linkage process that is central to “bridging and transitioning” is designed to maximize the chances that a given client will get “hooked in” to community-based, continuing care. The initial phase in this process, opening the referral, includes: (1) orienting the client to the particular recovery support society he or she has chosen to explore and (2) providing a direct, human connection between the client and either a representative of a recovery support organization or his or her first exposure to meetings of that society (Nealon-Woods, Ferrari, & Jason, 1995). The second phase in the active linkage process is closing the referral. Whereas the first stage guided the client into a relationship with a community of recovered and recovering people, the second stage is designed to ensure individual-group fit by assessing the strength and durability of the relationship between the client and the group. Such assessment can be incorporated into routine post-treatment check-ups (White & Hagen, 2005).

Successful implementation of “bridging and transitioning” programming also depends on the availability of ecological frameworks conducive to the knowledge transfer of skills learned during acute treatment to the natural environment. In this regard, sober living en-

These emerging models of recovery support services will need to be rigorously evaluated to determine what unique combinations and sequences of services generate the best long-term recovery outcomes. Advocates of the "bridging and transitioning" approach suggest that this type of sustained support may provide a less expensive and a more clinically effective alternative to recycling people through multiple episodes of acute treatment (Granfield & Cloud, 1999). Future research will determine if this new vision of continuing care is capable of producing improved clinical outcomes and a better stewardship of community resources.

### Call to Action

As with any paradigm shift, widespread implementation of "bridging and transitioning" programming will likely face some obstacles. In today's environment of managed care and professionalized addiction treatment, relationships between treatment organizations, local mutual recovery groups, and indigenous community support systems have been seriously eroded (Ito & Donovan, 1986). Furthermore, state policies, guidelines, licensures, and funding streams have evolved to support traditional treatment programs and, as a result, will require some changes to support the application of more client-centered, longer-term (e.g., 12 to 24 months), and community-based programs (Moos & Moos, 2005). To successfully negotiate these challenges, treatment agencies and treatment professionals must be prepared to strengthen their relationships with diverse communities of recovery and enhance and individualize their strategies for linking clients to particular communities of recovery (Miller & Rollnick, 1991).

We, as counselors, researchers, and educators with expertise in community psychology, are uniquely positioned to help facilitate these change processes and advance this new paradigm of addiction treatment. Through research and action, we can work to develop community partnerships that will promote sustained recovery through "bridging and transitioning" to community-based resources. ■

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