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Gender-specific Recovery Support Services:
The Evolution of a Woman's Recovery Community Center

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Introduction

It was not long ago that addiction treatment and recovery was a man's world. The treatment field's organizations were directed and staffed by men, served primarily a male clientele and utilized theories and techniques drawn exclusively from male experience. Recovery support groups were similarly male-dominated, and women seeking entrance to them faced considerable obstacles to their recovery (White, 1996).

That world changed through the efforts of pioneering women whose lives are finally being celebrated (White, 2004). In the intervening years, we have learned as a field that there are important gender differences in almost every important dimension of addiction, treatment and recovery (Kandall, 1996; Wechsberg, Craddock, & Hubbard, 1998; Walitzer & Dearing, 2006). These new understandings paved the way for gender-specific treatment programs and recovery support groups designed specifically for the needs of addicted women and their families (Schliebner, 1994; LaFave, 1999; Uziel-Miller & Lyons, 2000; Kaskutas, 1994) and expanded the range of settings in which women with alcohol and other drug problems could be identified and served (Grella & Greenwell, 2004).

One limitation of the gender-specific service innovations of recent decades is that they have been developed inside an acute care model of addiction treatment that is ill-suited for women with high problem severity and complexity and low recovery assets. As a result, those advocating a shift in addiction treatment from an emergency-room model of brief biopsychosocial stabilization to a model of sustained recovery support are also calling for the design of these new models to meet the unique recovery support needs of women and people of color (White & Sanders, 2004). This shift to models of sustained recovery management is birthing new and renewed social institutions (e.g., peer-operated recovery support centers, recovery homes) and new and renewed service roles (e.g., recovery coaches, outreach workers), but we are in the earliest stages of designing these institutions and roles to meet the needs of recovering women.

The purposes of this article are to briefly describe the emergence of the recovery support center as a new indigenous service institution, profile the history and service components within the Women's Community Recovery Center in New Britain, Pennsylvania, and highlight some of the lessons learned from the Center's first 18 months of operation.

Recovery Support Centers

There are a multitude of needs people experience over the course of their recovery from severe alcohol and other drug problems that are outside the traditional service scope of addiction treatment programs. The growing recognition of the need for non-clinical recovery support services is generating new models for delivering such services. One such model is the recovery support center (RCC). Usually operated by a grassroots recovery advocacy organization (see www.facesandvoicesofrecovery.org for a directory of such organizations), the RCC resembles the social fellowship of an AA clubhouse and the service orientation of a social service drop-in center. The Connecticut Community of Addiction Recovery (CCAR) describes its RCC as 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. (From Core Elements of A Recovery Community Center, CCAR, 2006)

The development of regional RCCs in states like Connecticut and Vermont marks a new approach to the delivery of non-clinical recovery support services. The RCC “moves recovery from ‘the church basements to main street,’ provides a venue for sober socializing, a physical place for recovery development (linkage to recovery-conducive employment, recovery homes, recovery workshops, planned leisure activities, community service work) and serves as a medium for connecting people with recovery needs to people with recovery assets.” RCC’s also function as “an organizational/human bridge between the professional treatment community and the recovery community” (White & Kurtz, 2006, p. 32).

Because of their service orientation, it would be easy to see the emerging RCC’s as simply a new level of care within the existing treatment continuum of care, but RCC leaders reject such a view. They emphasize that what they are providing individuals is not treatment but recovery support services that are designed and delivered, not by clinically trained professionals, but by and for people in recovery. RCC leaders also emphasize that such services are part of their larger goal of developing recovery capital within local communities of recovery and the larger communities in which they are nested—an approach that blends individual and family support models with models of community organization and cultural renewal (McCarthy, 2006; Valentine, 2006).

History of the Woman’s Community Recovery Center

The Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) was established in 1997 as a grassroots recovery advocacy organization. Its founding goals were to mobilize the members of the recovery community to reduce the stigma of addiction, to educate the public about addiction recovery, and to help shape pro-recovery public policies. In 1998 PRO-ACT received a Recovery Community Support Services Grant from the Center for Substance Abuse Treatment that provided the opportunity to expand PRO-ACT’s role within the community and begin to provide Peer Driven / Peer Delivered recovery support services throughout Southeastern Pennsylvania. Thru a highly participatory planning process, PRO-ACT has developed a wide variety of

recovery support services designed to help individuals and families initiate and sustain long term recovery and has extended the range of its service focus from it's origin in Bucks County to the City of Philadelphia. The latter move has been sparked by a recovery-focused behavioral health care systems transformation process being led by the Philadelphia Department of Behavioral Health (White, in press). BEV: I WAS TRYING TO FIND A PLACE TO ACKNOWLEDGE DBH; LET ME KNOW IF YOU THINK THIS REFERENCE IS OKAY.

One of the early projects (INSERT YEAR) developed by PRO-ACT was Mentor Plus which matched volunteer Mentors with inmates in early recovery (“Mentees”) residing at the Buck’s County Correctional Institution. The Mentors visit their assigned Mentees once a week during the Mentee’s incarceration. The focus of these visits was to develop a recovery plan for that would be implemented upon the Mentee’s release. As the program evolved it became clear that female Mentees had a great deal more difficulty transitioning out of the institution and implementing a recovery plan than did their male counterparts. The special needs of female Mentee’s included safe housing, early financial assistance, recovery-conducive employment, assistance with family problems, support for continued education, and linkage for assistance and support for co-occurring medical and psychiatric illness.

At the same time these needs were being identified, another committee within PRO-ACT was exploring the Recovery Centers that were being established in Vermont and Connecticut. Out of that synergy of circumstances, PRO-ACT naively developed the idea of developing a Center that would combine the goals of providing recovery housing for women who needed it and providing a recovery-oriented, gender-specific sanctuary for other women in the community within this same facility. In September of 2004, PRO-ACT and its host organization (Bucks County Council on Alcoholism and Drug Dependence, Inc.) was awarded a subcontract from Northrop Grumman to reduce the incidence of Fetal Alcohol Spectrum Disorders within our already existing MOMS program which had been providing outreach, support ,and intervention services to pregnant women in the community . The grant allowed for expansion of services to any woman wishing to initiate or sustain recovery. In December of 2004, The Council purchased a building that once served as a women’s college dormitory in New Britain, Pennsylvania for use as a Women’s Community Recovery Center. The Center was opened to the Community in May 2005 after months of work establishing a steering committee, fund-raising, attending zoning hearings, hiring staff, recruiting and training volunteers, and developing policies and service procedures.

Forty-eight volunteers were recruited and trained as recovery coaches and a 12 session Life Skills program curriculum was developed to address the problems and needs that women seeking recovery were most often experiencing. In January of 2006, with great excitement, the first 5 women entered the house as residents. Volunteers and professional staff worked together to continue to outreach to the community while providing recovery support services to the residents. During 2006 the number of residents grew as we moved toward the facility’s capacity of 18 women.

Meeting the demand for housing quickly dominated our efforts and became what seemed an overwhelming task. Screening potential residents, providing recovery support for those women living in the Center became the focus for both the staff and volunteers. As this occurred, the number of women living in the community and participating in the

WCRC declined. In March of 2007, the staff began an evaluation process to look at what has been the experience to date of the Center, the peer volunteers, the staff and the women who have participated whether as members of the community or as residents. In the remaining sections of this article we will profile the women served by the Center, the core services of the Center and the lessons we learned through this novel experiment of combining within the same facility the provision of recovery housing and the delivery of non-residential recovery support services to women in the community.

Profile of Women Residents

Over the past year and a half, 28 women, aged 19-47, have lived at the Women's Community Recovery Center (WCRC). These women presented with variable educational histories (7 without high school education; 13 with high school graduation or GED, 6 with some college work, and 2 college graduates), a history of unstable employment, and significant (25 of 28) legal involvement due to their past alcohol and other drug use. Multiple drug use was the norm among women residents with only 5 of 28 women using alcohol only. Of the 28 residents served since January, 2006, 9 were addicted to heroin and 14 to one or more forms of cocaine. All residents had received some level of drug and alcohol treatment prior to entering the WCRC and some had multiple episodes of past treatment. Twenty-one residents had prior involvement in a support group such as AA or NA prior to their admission to the WCRC. All residents had experienced more than one relapse, with many presenting with chronic re-occurring relapse histories.

Nineteen residents are mothers and another was pregnant at the time of her exit from the WCRC. These nineteen mothers had a total of 47 children and 15 of the 19 had current or past custody problems or other serious parenting issues that had brought many to the attention of Children & Youth Services. Twenty-four of the 28 residents came from a family where at least one (usually more) relative had a problem with alcohol or other drugs. In addition to family of origin alcohol and other drug abuse, most residents were actively involved or had been involved in the past with a significant other who had a history of alcohol or other drug abuse.

Twenty-two of the residents reported physical health problems/diagnoses prior to admission. These problems ranged from Hepatitis C (10 out of 28 residents) to such problems as hypothyroid conditions, Hodgkin's Lymphoma (in remission), diabetes, arthritis, emphysema, asthma, hypertension/high blood pressure, anemia, herniated/degenerative discs, scoliosis, knee problems, kidney stones, dental issues, back pain, and migraines. Twenty-one of the women had at least one psychiatric diagnosis and 11 had more than one diagnosis at the time of their admission to the WCRC. The most prevalent diagnoses were depression, bipolar disorder, and anxiety disorders. Most of the residents reported prior psychiatric treatment and most were taking medication for their psychiatric diagnoses during residency. They were often on more than one medication, and several of the residents who were on psychiatric medications were also on methadone maintenance therapy.

Several residents had experienced one or more inpatient stays at mental health treatment facilities. At the most extreme, one resident had been hospitalized for mental health concerns a total of 8 times, 4 of those times because of suicide attempts. Other

residents were/are under the care of a psychiatrist to manage their mental health symptoms, most receiving psychiatric care through a local outpatient facility or through the psychiatrist at their drug and alcohol treatment program.

The majority of residents (22 out of 28) had a history of trauma prior to coming to the WCRC, with reported trauma ranging from childhood or adult physical, sexual, or emotional abuse; rape; witnessing violence; death of a child, and extreme neglect. Not only had many residents experienced sexual, physical, and/or emotional abuse or neglect as a child, but many also experienced various types of violence within their adult relationships, including physical and emotional abuse by partners as well as rape and sexual assault by partners and/or strangers.

It can be seen from this brief profile that the women admitted to residential recovery support presented histories of great severity, complexity and chronicity, and in spite of their recent treatment histories, great acuity. The implication of this profile to WCRC's self-assessment of its own capabilities will be discussed shortly. PROFILE OF COMM PARTICIPANTS? CAN WE CONTRAST?

WCRC Services

The women staying at the WCRC are expected to pay rent, but due to their poor financial status and difficulties in obtaining employment, many of the past residents left the WCRC owing rent money. (Past residents have collectively paid \$17,050 of a total of \$23,000 due for rent.) During lengths of stay ranging from less than 2 weeks up to 40 weeks, the WCRC residents. The Center is staffed by # paid positions: a Women's Services Manager and a Volunteer Coordinator INSERT AND OTHER TITLES and currently more than __# volunteers. Case managers are made available to the residents to help to deal with the many problems residents experience navigating the traditional treatment system and to help identify and connect the residents with other community resources. Case managers and peer volunteer recovery coaches worked with the residents to develop and implement recovery plans. Service activities in general case management, recovery coaching, social support, education and skill building groups, and crisis management. ADD ANY MISSING ELEMENTS HERE. Center programming has expanded to include a monthly calendar which is published and open to any woman in the community. Programming includes a lecture series, Life Skills workshops, Parenting, Craft/ Cooking night, Bible Study, and presentations/discussions facilitated by volunteers on health and appearance.

Nearly all residents are enrolled in outside professionally-directed addiction treatment while living at the Center. These treatment services are provided by _____ (a variety of community-based treatment organizations?) While living at WCRC, all residents are strongly encouraged to attend recovery support group meetings such as AA or NA. WCRC residents run their own AA meeting that is open to the community every Monday evening at the Center. The degree of connection between WCRC residents and the local recovery community and local support groups has varied from very strong to those who never truly becoming engaged with the local recovery community.

One of the biggest challenges WCRC staff and volunteers have faced is how to provide true recovery support services instead of treatment services. Working with

residents who present such a wide range and intensity of problems while living at the Center has a tendency to shift staff and volunteers out of their recovery support role toward a counseling role, which is unintended and inappropriate. This pull towards this clinical role is particularly strong in the face of relapse. Half of the residents (14 out of 28) had a known relapse while in residency. A relapse often led to the exit of the client shortly thereafter, whether to a higher level of care, or client leaving against staff advice. Where many residential treatment programs will administratively discharge clients who have relapsed, the WCRC staff and volunteers are willing to work with the client who relapses. While residency at the WCRC is not considered a level of treatment, the idea of working with a client who has relapsed and allowing her to remain in residence is a revolutionary one. For residents who relapsed, staff examined the situation to determine the best course of action, whether that meant facilitating a referral to a higher level of care for the client, or in helping the client develop a more effective relapse prevention plan. However, residents did not always respond positively to these staff efforts.

In its two years of operation, WCRC was able to establish a residential recovery support center, recruit and train a core cadre of volunteers, develop a set of core services (including a well-attended 12 step meeting at the Center), establish a sound referral base, and engender strong local community support. Perhaps even more importantly, 22 out of 28 women obtained employment, 12 out of 19 mothers in residence began visitation with their children, all residents were linked to the local recovery community, 8 have remained involved with WCRC services after they left residence and 3 are active volunteers working with other women seeking recovery.

The following three case studies further illustrate the characteristics of WCRC clients and WCRC recovery support services. (Names have been changed.)

Marie is a 36 year old Caucasian female, single with one child with special needs. She has one older sibling, her parents are divorced, and her mother has remarried. She was referred through Aldie Counseling Center for residence. She presents as homeless, and is on prescribed Methadone as well as anti-depressant and sleeping medications. Marie is engaged in ongoing addiction and psychiatric treatment. During residence, she attended the 12 week life skills program, attended 12 Step meetings, and engaged with a Recovery Coach and a 12 Step Sponsor. Marie was able to regain joint custody of her son, and successfully complete all of her Probation and Parole requirements. She also became gainfully employed and disenrolled in Medical Assistance. She displayed patterns of taking on roles of responsibility, becoming overwhelmed, then sabotaging herself. She opted to take a career position and relocate to her parents' home despite staff feedback about this choice. She subsequently relapsed, but was able to return to treatment quickly and re-stabilize. She is currently working part time, and is actively involved in Programming (WHAT IS THIS? WCRC services?), Life Skills and volunteer activity at the WCRC, while she and her son are living with her parents.

Faye is a 28 year old Caucasian female, single with no children. She is youngest of 5 children and her parents remain married. She was referred through Aldie Counseling Center for residence. She presented as homeless with a past history of treatment for ADHD, but was not taking prescribed medications. She was

actively engaged in addiction treatment and mental health services at the time of her entry into WCRC. During residence, she attending programming activities (WHAT IS THIS?), the 12 week life skills program, attended 12 Step Meetings, as well as engaged with Recovery Coach and a 12 Step Sponsor. She entered the WCRC with private insurance and was unemployed. Faye achieved employment in retail, despite a college degree. She maintained the same job throughout her stay of 18 weeks. She completed the program successfully and moved on to rent a room from a woman in the Recovering Community. Faye continues to be involved in ongoing activities at the WCRC. She currently works in sales and was able to pass her licensing test with support from staff. She manages her ADHD through biofeedback rather than medication. She has maintained abstinence since her discharge.

Hope is a 26 year old Caucasian female, single with 2 children. She is youngest of three children, her parents are divorced, and her father has remarried. She was referred through BCCF (SPELL OUT) for residence. Hope presented as homeless and with a history of Bipolar Disorder treated with a prescribed mood stabilizer. She became actively involved in addiction treatment and mental health services through Aldie Counseling Center. During residence, she attending all of WCRC's service programs and became actively involved in a 12 Step Program. Hope achieved employment during residence. Through staff at WCRC, she became involved with Bucks County Opportunity Council's self sufficiency program to seek financial assistance. She rented an apartment in the area, and continues to be employed. She recently received scholarships through the BCOC (SPELL OUT) as well as the Bucks County Chamber of Commerce for Beauty School, which she began in June 2007. She has maintained abstinence and continues to be actively involved in ongoing activities at the WCRC.

INSERT COMMUNITY CASE STUDY

Lessons Learned

WCRC was founded on the belief that gender-specific recovery support services could be combined with professionally-directed treatment services to enhance long term recovery outcomes. After two years, we still believe in the importance of such services, but we have learned many lessons about the challenges of implementing and sustaining such services. In reviewing our experiences of the past 24 months, the following are among the most important of such lessons.

BEV: EDIT LIBERALLY; FEEL FREE TO ADD CATEGORIES. JUST SUMMARIZE TIGHTLY SO EACH ONE IS ABOUT THE SAME LENGTH. EACH ONE OF THESE COULD BE A PAPER. WE JUST WANT A TIGHT SUMMARY HERE.

The Planning Process: The key word is inclusion: inclusion of the community via volunteers and inclusion of service recipients in the refinement of services over time. WCRC relied extensively on volunteers from the community to form the work groups

that develop rules and structure for the residents, as well as to develop the life skill building workshop curriculum. Volunteers also met to develop committees for fundraising, décor/ Center maintenance. We adhered to a “learn as you go” philosophy, letting our interactions with service recipients guide the ongoing evolution of WCRC services.

Co-location of Services: The central question WCRC has faced is this: Can a recovery home and a recovery support center co-exist within the same physical facility? After two years of attempting such co-location, we would offer the following advice. These are significant differences in needs of women in the community versus the needs of women needed residential recovery services. Responding to the overwhelming needs of the WCRC residents and the limits imposed by the physical design of the WCRC facility have prevented significant community participation. We suspect that co-location will result in doing one or the other function well but that it would be very hard to maintain a level of excellence in service to both women in residence and women in the community. BEV MAKE SURE THIS IS CORRECT: FILL IN YOUR CONCLUSION ON THIS QUESTION.

Staff/Volunteer Recruitment, Training and Supervision: Effective recovery support services rest on the principle of continuity of contact in primary recovery support relationships over time. Achieving that continuity requires retention of staff and volunteers, which in turn requires a high level of technical and emotional support for their efforts. That support is best demonstrated by rigorous screening and selection, structuring orientation and on-going training programs, ready availability for consultations on difficult situations, and regular opportunities for staff and volunteer recognition.

Volunteer Risk Management: Actions that volunteers take or fail to take can jeopardize the future of the best recovery support programs. This risk can be minimized by performing background checks on all applicants to serve as volunteers¹, training volunteers in ethical decision-making, provided ethical guidelines for peer-based recovery support services, and through close supervision.

Role Clarity: The scope and severity of the problems experienced by women entering WCRC challenged us to remain in our **non-clinical** recovery support roles. This required constant reminders to staff and volunteers that we were NOT counselors or therapists and that our job was not to fix problems but to facilitate recovery initiation and maintenance. This required significant attention in training and supervision.

Gender-specific Barriers to Recovery: The lack of family support, the multiple role demands, the lack of financial resources, the past criminal records, and their own identities as outsiders severely limited the choices and access to community services of the women served by WCRC. The histories of trauma and the resulting patterns of emotional volatility and relationship instability further compromised the ability of these women to achieve stable recovery. This is not to say that recovery is impossible, but that it requires a more complex and enduring support process than we had anticipated.

¹ A criminal background check is not intended to automatically disqualify people who have such a background (many people in long-term recovery with notable community service have such a background); the background checks are intended to screen out individuals who have an established pattern of predatory behavior who may be looking for new venues through which they can exploit vulnerable individuals.

Diversity: We have found that one of the most important dimensions in the delivery of recovery support services is a broad representation of pathways and styles of recovery among staff and volunteers. Ideally, people being served should be brought into contact with the full scope of such styles, including the 12 step community, faith-based recovery ministries, secular programs of recovery and those in medication-assisted recovery. That diversity should also be reflected in the age and ethnic composition of staff and volunteers.

Medication Management: We had not anticipated the number of women we would serve who would be on prescribed psychotropic medication. That discovery demanded our attention via assuring continuity of medication access (e.g., women medicated in jail but given no medication upon their release to enter WCRC), procuring a safe to secure medications, establishing a medication log to track medication consumption, staff education on medications and side effects, and increased communication with prescribing physicians.

Facility Security: There were more security issues than we had anticipated, e.g., women trying to sneak out to visit boyfriends. Given the crucial importance of physical and psychological safety in the delivery of women's services, we were forced to heighten security via a curfew, the use of security cameras and key fob system.

Relapse Management: We were unprepared for the level of problem severity (and the accompanying in residence relapse rate) of those we served. While we supported the philosophical position that our response to women who relapsed should be one of early re-intervention and support, this was hard to operationalize. Training of staff and volunteers about the chronic nature of severe drug dependence and the principles of long-term recovery management helped us sort through the best options in the face of such relapse incidents.

Use of Community Resources: The key to effective recovery support centers is aligning the power of local community resources in support of recovery initiation and recovery maintenance. It was very important for us to establish constant and consistent communication with outside agencies to help our residents access the services that they needed, as well as to help keep us up to date on changes in our residents' status with other community agencies.

Summary

Calls to transform addiction treatment into “recovery oriented systems of care” are triggering new experiments in the delivery of pre-treatment, in-treatment and post-treatment recovery support services. Two such experiments involve the proliferation of self- or staff-managed recovery homes and the rise of recovery support centers. This paper describes the attempt of the Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) to operate a gender-specific recovery home and a recovery support center within the same facility in New Britain, Pennsylvania.

In its first two years of operation, the Women's Community Recovery Center (WCRC) served 28 women in residence while attempting to also offer recovery support services to women in the larger community. The needs of the women being served in residence were so great and so complex that responding to these needs consumed the majority of staff and volunteer resources. Some of the critical lessons learned from this

experience include the importance of community and consumer involvement in the planning and implementation process, the necessity for boundary management between clinically-oriented treatment services and non-clinical recovery support services, the importance of volunteer training and support, and the value of assertively linking the women being served to local communities of recovery and other formal and informal resources in the community.

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