

The RETREAT

perspectives

Spring & Summer 2003

Living experience, strength & hope



FOR NEARLY 200 YEARS, WE AS A SOCIETY HAVE CLAIMED THAT ADDICTION IS A CHRONIC, PROGRESSIVE DISORDER. BUT I AND OTHERS WOULD ARGUE THAT WE'VE NEVER TRULY ACCEPTED THIS BELIEF BECAUSE OUR ACTIONS BELIE IT.

BY WILLIAM L. WHITE

The treatment renewal movement: *Reconnecting treatment to recovery*

THE MODERN ERA of chemical dependency treatment emerged in the 1970s with a virtual explosion of treatment and recovery programming. Tremendous progress was also made in destigmatizing alcoholism and other addictions as hundreds of thousands of people entered recovery. Betty Ford's national address in which she declared that she was recovering from addiction to alcohol and other drugs epitomized the new-found openness and optimism of this decade. In 1980, however, the Reagan administration swept into the White House with a completely different philosophy and approach to this social problem. Alcoholism and other addictions were re-stigmatized and subsequently de-medicalized (with the erosion of health care benefits for treatment and closing of hospital programs) and, finally, re-criminalized (marked by a massive transfer of responsibility from public health systems to the criminal justice system). The "zero tolerance" approach of 1980s and much of the 1990s stood in stark contrast to what was, in retrospect, the field's "Camelot" period.

Three years into a new decade and century, two very positive movements are emerging to counter these regressive

trends—the treatment renewal movement and the recovery advocacy movement.

A disconnect between treatment and recovery

Today there is a growing sense in the field that treatment has somehow become disconnected from the larger and more enduring process of recovery. To understand how this came about, we need to look back to the 1960s and 1970s. Recovery advocates of that era had a vision of a large recovery arena, with treatment providing a needed doorway of entry for those individuals with special obstacles to recovery. Treatment itself was considered necessary only for the people who couldn't access the larger circle of recovery on their own. Thirty years later, those same advocates see a large treatment industry that all too often views recovery as an afterthought. The message is a clear one: it is time we reconnected treatment to recovery and made the former an adjunct of the latter.

For nearly 200 years, we as a society have claimed that addiction is a chronic, progressive disorder. But I and others would argue that we've never truly accepted this belief because

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A RAY OF HOPE

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**SAME LOCATION,
new street address!**

No, The Retreat did not move, but our street address has changed.

Here's our new address:
The Retreat,
4200 Upland Farm Road
Excelsior, MN 55331.

treatment renewal

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our actions belie it. If we really accepted addiction as a chronic disorder, we would not create the expectation that everybody should or could get well from a single brief intervention. Secondly, we wouldn't consider people with prior treatment to have a poor prognosis for recovery. Third, we wouldn't throw people out of treatment for becoming symptomatic while receiving treatment. This is virtually the only health disorder for which you are denied treatment if you exhibit the symptoms that led you to seek it. And finally, we would not continue to treat addiction with brief episodes of disconnected care in which the service relationship is terminated following intervention.

In reality, we continue to treat addiction like it's a broken arm or a bacterial infection. We do so with brief interventions that have a beginning, middle, and end, and then assume that the problem is taken care of. Strong evidence shows, however, that many people cycle through this "acute model" time and again, which demonstrates clearly that addiction is a chronic, not acute, disorder. For this reason, we need a radically different way to approach and treat it.

Treatment, critics would say, got caught up in processing people and paper and in making profits—while losing its historical vision of long-term recovery. The treatment renewal movement in part seeks to reconnect treatment and recovery, placing far less emphasis on the acute model of intervention and more on recovery management. Advocates suggest that to begin this process, we need to jettison our current concept of aftercare and instead focus on providing much more recovery monitoring, support, and coaching—care similar to that given to people with other chronic disorders like heart disease, diabetes, and arthritis. The focus of treatment would thus shift from detoxification and stabilization to ongoing monitoring and support, stage-appropriate recovery education, early re-intervention as needed, linking the individual to a larger recovery community, and periodically doing what we might term "recovery checkups."

Treatment institutions to often work isolated from communities

Renewing and strengthening linkages to the broader community raises a second treatment renewal movement theme. At some point along the road to "professionalization," treatment agencies became increasingly isolated from the very communities from



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which they emerged. In the 1950s and 1960s, grassroots movements birthed large numbers of treatment programs. In subsequent decades, however, program staff became more "professionalized," and increased funding enabled the construction of beautiful buildings (in which, I would argue, we've become imprisoned). As a result, the field's primary preoccupation today seems to be on getting individuals into treatment. Once there, we help clients look at their values, beliefs, skills, and

attitudes—and then we return them to environments that all too often devour them.

The question ought to be refocused. Rather than asking how to remove a person from their environment and get them into a facility, we should ask how we can nest a person's recovery in his or her natural environment. If someone calls a treatment center for help, the first question they hear ought to be, "Have you contacted sources of support in your community (such as A.A., N.A., a sponsor, a faith-based group, or secular organization, for example) for your problems?" In this view, treatment centers no longer serve as the first line of response, but rather as the community's final safety net. In addition, we must begin to organize recovery communities where none exist and support those communities where they do exist. We in the field need to ask ourselves whom are we really serving most: ourselves or the broader community?

Multiple pathways to recovery

Another important and positive change in the field is the growing recognition that there are multiple ways people get into difficulty with alcohol and other drugs, and that these patterns differ markedly. As a result, treatment needs to be more differentiated—one "size" just doesn't fit everyone.

Many people argue that we need more treatment, and that may be so in some communities. A far more pressing need, however, is for the recovery circle to become much, much larger and better interconnected. We have moved too deeply into the clinical-biomedical-psychotherapy model, and now it's time to rediscover the community's role in healing and long-term recovery.

A recently completed study of twenty-three women's programs conducted by Chestnut Health Systems showed, for example, that after 12 to 18 months in recovery, many African-American women migrate to their churches for a primary base of sobriety support. If this is true, we should invite such churches to work with us and we should be supporting their efforts. We ought to celebrate any path through which people recover. This groundswell of effort to reconnect community and recovery through the use of sober living residences and ongoing recovery support services is a very positive sign.

The Retreat provides an example of this grass-roots process where we reconnect to the community and build “natural” support systems for people in recovery. In The Retreat, we have a place that is not so much an agency as it is a focal point for the recovery community. And while some may claim The Retreat is doing “treatment,” I would argue that they are actually about recovery.

Re-involving recovering people as peer service providers

Alcoholics Anonymous was founded by recovering people who wanted to help others trying to recover. For many years, individuals in recovery played a vital role in all aspects of treatment. During the past twenty years, however, many were forced out of the field because of escalating credentialing requirements. We need to bring these people and their valuable expertise with recovery back into the system, not to be “professionalized,” but as a resource base whose focus is on recovery. And this tide, too, seems to be turning. We now see a growing cadre of outreach workers, recovery coaches, recovery mentors, and recovery support service specialists who are very familiar with their local recovery communities. Their goal is not to supplant the traditional service ethic of local communities of recovery or the traditional role of the sponsor, but rather to help steer those in recovery to the community resources that best fit their needs.

The recovery advocacy movement

Until fairly recently, cancer was seen by many as such a frightening, highly stigmatized, and imminently fatal disease that people would scarcely utter the word. That attitude began to change when we reached a point at which nearly everyone knew someone who’d had cancer—and who’d survived. Likewise, most people today know someone in recovery, but they don’t know the person’s in recovery—and that needs to change. The recovery advocacy movement is calling for a vanguard of recovering people—those who have continuous sobriety of 5, 10, 15, 20, or 30 years—to step forward and boldly proclaim their recovery status. We are not asking anyone to violate anonymity; we just want people to stand up and say, “I once had this problem, and now I don’t anymore. And this is how my life has changed.” Society needs to regularly hear the message that people *can* get well from addiction—because many have done so. By once again putting a positive face and voice to recovery, we can again begin to destigmatize addiction and widen the pathway of entry into recovery.

If you would like to read more about the new recovery advocacy movement, William White’s papers on this subject are posted on the Web at:

www.facesandvoicesofrecovery.org



MOLLY McGLYNN VARLEY JOINS THE RETREAT BOARD

THE BOARD OF DIRECTORS

of The Retreat recently welcomed its newest member, Molly McGlynn Varley, who brings a wealth of community service experience to her position. Varley currently serves as President of the McGlynn Family Foundation. She has also served as a Trustee for the College of St. Benedict, President of the Junior League of Saint Paul, and a member of Friends of the St. Paul Public Library Board. In addition, she has volunteered at St. Luke’s Catholic Church, and the St. Paul Academy and Summit School.

Varley says she accepted the invitation to join The Retreat Board for a number of reasons. “Most importantly, I know of many people who have begun recovery as a result of The Retreat. That’s fantastic. And on a more personal level, I’ve done a lot of volunteer work over the years, but never in the recovery community. I just felt it was time to get more involved, and this position seems like a perfect fit for me.”

Varley, who is nearly twenty years sober, views The Retreat as a key resource for two important communities. “First of all, of course, its programs serve chemically dependent men and women who want to begin a life of sobriety. In addition, The Retreat provides tremendous opportunities for people in the recovering community to be of service to others. I’m very excited to have this opportunity to contribute to The Retreat’s work.” And jumping right into her work, Varley has graciously agreed to serve with Kathrine Hill as co-chair for The Retreat’s events committee which will spearhead 2003 fundraising event(s).

Replicating the “Retreat” model: *Our next challenge*



JOHN CURTISS

NEARLY FIVE YEARS AGO when The Retreat opened its doors, our goal was to create a non-clinical, affordable recovery program that would exist outside the traditional healthcare delivery system and provide support and education through a community-based Twelve Step model of care. Our model was seen by some

as radical, since few in the treatment field were moving in this direction. We did not, however, invent something new, but merely re-introduced a proven method of recovery. The Retreat rests on the solid historical foundation of such pioneering programs as Bill W. and Marty Mann’s High Watch Farm, which opened in 1939 as a recovery retreat in Kent, Connecticut, and Hazelden’s original “Old Lodge,” which opened in 1949 in Center City, Minnesota. The Retreat adopted some of the basic principles of these and other such models while enhancing community and professional relationships and deepening the teaching of the Twelve Step principles of recovery embodied in the *Alcoholics Anonymous* text.

Our founding core precepts represent both what was innovative and traditional about our program. We wanted to reintroduce this original “retreat” idea, thus returning to a simpler more affordable model of recovery and reemphasizing the spiritual nature of the recovery process. But to be frank, we were not sure a model like this could exist today—by which I mean that it would help people recover. Nor were we certain that we could provide services for our guests at an affordable price and remain financially viable. Nearly five years later, we’re pleased to be able to say that we are succeeding on both counts.

Having fulfilled the first part of our mission—to create a residential recovery model that is affordable, accessible, and effective—we are now turning our efforts toward another important goal: to replicate our model in other parts of the country. From the beginning, replication of The Retreat has been an integral part of our mission and vision. For the past several years, numerous individuals and groups from across the United States and abroad have sought to learn more about what we do and have expressed interest in replicating our model. They include physicians in Hong Kong and Beijing, and other groups in Russia, England, and Ireland.

After careful deliberation, The Retreat’s Board of Directors decided to move ahead and embrace this next challenge. We are certain that The Retreat’s success has been based neither on luck nor on an environment unique to Minnesota. We have identified the key elements that have made our success possible, and we believe that if they are present in other communities, new Retreat-like settings can develop and succeed.

We spent the past year examining three potential replication sites—in Dallas, Chicago, and Seattle—which have the

criteria needed for success. We are currently looking most closely at Chicago, and we hope to make a final decision by mid-year on where we will focus our efforts. This year, we are working to identify property in which to locate the program and to gather the necessary local individuals who will champion this effort in the areas of philanthropy, leadership, curriculum delivery (particularly Big Book study), and volunteerism through A.A. and Al-Anon. We will also focus on obtaining appropriate licensing and hiring an executive director and staff.

We have decided to own and operate this new “Retreat,” primarily because we would like to have control over the details of our first replication effort. The long-range goal of The Retreat and CORP is not, however, to create, own, and operate Retreat projects across the country. Rather, it is to plant seeds that will, in turn, attract sufficient attention to set in motion a trend to develop other successful, affordable, and accessible recovery models here and abroad.

To further support future replication efforts, we are creating *The Complete Retreat*, a book that will describe and outline every step in the process of developing a model such as The Retreat. When we began to develop The Retreat model, a long-time friend and supporter strongly encouraged us to articulate, in writing, each step of this model’s development. With the help of a professional writer, *The Complete Retreat* first will provide an historical perspective of the community-based, supportive-educational model and describe the trends in the alcoholism treatment field that made the re-emergence of such a model so timely. Then the book will carefully describe what it takes to set up such a model, including guidance on selecting a board of directors, creating policies and procedures, hiring staff, developing financial and marketing plans, fundraising, educational curriculum, creating the necessary linkages to the professional community, and the development and support of a volunteer network. Having such a manual will enable us to help others without having to be too directly involved with the replication process.

As excited as we are about the success of The Retreat and of the prospect of seeing new “Retreats” emerge, we are not saying that our model is the next “be all and end all” of treatment, or that it should, or will, replace current models. On the contrary, we firmly believe that we need a full continuum of recovery services—from models that are highly clinical and multi-disciplinary in nature to models that are less medically intense, less clinically focused, more community oriented, and affordable. [Please see Bill White’s article in this issue—Ed.] At the same time, we want to challenge the current treatment and healthcare paradigm that says that to be effective, treatment centers must provide all clinical services on-site. The Retreat’s model demonstrates that it is possible to effectively offer clinical services for those who need them by utilizing already existing community resources—and in so doing, all guests need not pay for services that only a few need.

As we move ahead in this exciting endeavor, we will continue to take care of and improve our current Twin Cities Retreat programs and services. Our new challenge will

BY GEORGE MANN

Why must they suffer

THE YEARS BETWEEN 1970 AND 2000 were a period of almost constant breakthroughs in the treatment and management of a wide range of chronic medical problems. Remarkable and effective new drugs, surgical procedures, and technologies were developed to address these problems. A glaring exception to this progress was in the area of chemical dependency.

During the 1970's and early 1980's, there was general acceptance within the health-care community that addiction met the criteria needed to be regarded as a chronic disease. Addiction to alcohol and other drugs, if adequately managed, was shown to be highly treatable with statistically positive outcomes, including a lifetime free of recurrences. The medical, law enforcement, and business communities seemed dedicated to addressing this national problem through the judicious use of proven clinical care. During the late 1980's and 1990's, however, we witnessed an almost complete reversal of this attitude. HMO's, bent on reducing healthcare costs dramatically, cut back on coverage for all chemical dependency programming, which resulted in the closing of many residential programs. The "war on drugs" became a national obsession, and addiction was re-criminalized.

Consequently, as we enter this 21st century, the people afflicted with this disease find themselves unable to obtain adequate and effective care due to this pervasive regression in societal attitudes. Chemically dependent men and women are increasingly stigmatized when seeking employment and insurance coverage, too often viewed as criminals, and plagued by harsh treatment in the criminal justice system.

In general, healthcare professionals recognize that success in dealing with chronic diseases lies in management and control. People with diabetes, hypertension, and arthritis, for example, are given a clear message that says, "your disease can be managed by specific medications, life style changes, and other adjunctive therapies used as they become necessary." Those with the chronic disease of alcoholism, however, are treated much differently. Alcoholics seeking help must pass a "needs assessment" test before they can even apply for help. They are then generally denied the level of care that all studies show will provide the best statistical chances for recovery. While receiving less than adequate care, they are often told by a therapist that they will likely relapse and require more [inadequate] care. The concept of total and permanent abstinence with regular participation in support therapies such as A.A. is seldom emphasized or recommended to clients to the extent that it once was. Clients are often told instead that



TODAY WE NEED TO CHANGE HOW WE VIEW

THIS DISEASE AND TO DEVELOP TREATMENT

STRATEGIES THAT ENCOMPASS THE

ENTIRE PERSON—BODY, MIND, AND SPIRIT.

they have a variety of psychiatric problems for which they will need to take psychotropic drugs for the rest of their lives—while they continue to relapse. While state and federal government agencies and the insurance industry spend millions of dollars collecting data, conducting studies, and comparing statistics to justify misdirected efforts to manage this disease, addiction continues to extract a terrible toll. It costs our society \$120 billion annually, as well as 100,000 alcohol-related deaths and large numbers of drug/alcohol-related murders, rapes and suicides.

The decision of these agencies to place addiction under the umbrella of mental health has been responsible for much of the devolution of care for this population. The psychiatric community has generally reject-

ed the idea of addiction as a primary illness, instead defining it as the manifestation of underlying psychiatric problems or disease. In other words, today's thrust in care is on treating the symptoms rather than the disease, and to direct the primary therapeutic effort to theoretical underlying psychiatric issues with the use of psychotropic drugs. As a result, very little money, time, or effort is spent treating addiction, while enormous amounts of each are expended to treat psychiatric problems that we know will often resolve themselves with time and sobriety.

This is not to say that neither psychiatric illness nor mental instability accompany addiction. They do, but it takes time to arrive at a correct diagnosis. By limiting time in a supportive recovery environment, however, patients are often prematurely and, as a result, incorrectly diagnosed and treated for the symptoms they present. Likewise, little time is available to teach the spiritual principles embodied in Alcoholics Anonymous and the tools of recovery needed to remain sober. Long-term talk therapy, psychotropic drugs, and repeated hospitalizations instead are seen as the answers for the predictable recurrences of addiction under this largely ineffective system.

In his recent State of The Union address, President Bush stated that he was earmarking \$600 million for the "effective" treatment of addiction. It is good news for the "Recovering Community" that the government may finally realize that treating addicts is a wiser investment than punishment and imprisonment. But exactly what will be considered "effective" treatment? How much of this money be spent for more studies and data collection? And will the money actually spent on treatment be used to work with the largest number of people in merely the most "cost effective modality." If so, this is a plan doomed to failure,

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GROWTH THROUGH COLLABORATION

THE STRENGTH OF THE RETREAT lies in its ability to effectively engage the community in the delivery of its services. Volunteers, donors, those in recovery, and many others work together to provide the multi-faceted support essential to meeting the needs of those seeking a life of recovery. This reliance on external partnerships requires that The Retreat engage and converse with its many constituencies and be responsive to their feedback and constructive suggestions.

These many partnerships have helped The Retreat to come a long way since it first opened nearly five years ago, and they remain vital to its future. To the 280 philanthropic partners who have generously given time, and in-kind, and financial contributions, we extend our gratitude and deepest appreciation. Thanks to tremendous community support, we now own The Retreat and one of the two sober houses we operate in St. Paul. This year, a donors' wall will be established at The Retreat to acknowledge, honor, and thank the individuals, foundations, and businesses that have supported our work.

2002 ACCOMPLISHMENTS

Last year, \$325,000 was raised in gifts and pledges, bringing total giving over the past five and a half years to \$2.2 million. The Campaign of Fellowship was completed in the first quarter of 2002, and the \$1.7 million goal was surpassed.

The inaugural Retreat event—a *Back to the 50s* gala—brought the community together to support a worthwhile cause. In fact, the idea for the gala and theme came from volunteers and friends of The Retreat. Led by Kathrine Lynden, more than 40 volunteers worked hard to make the gala a tremendous success—as well as loads of fun for the 250 people in attendance.

Eighty of the 252 men and women served by The Retreat in 2002 were beneficiaries of the \$48,000 in scholarships made possible through gifts from generous supporters of The Retreat. These funds were matched nearly dollar for dollar by H.E.A.R.T. (Help Every Alcoholic Receive Treatment), bringing total scholarship distributions to over \$100,000; we have been able to essentially double the value of each dollar contributed. Since inception, nearly \$200,000 has been provided in scholarships to help 261 men and women participate in The Retreat program.

LOOKING AHEAD IN 2003

2003 is shaping up to be an exciting and challenging year for The Retreat. A number of significant initiatives are either planned or underway that will markedly advance our mission. Donor support will be needed, however, for these endeavors to succeed.

Replication of The Retreat Model (\$250,000) Funds will pioneer this model in another community and be used to identify and secure a facility, obtain appropriate licenses, and hire an executive director and staff.



BRUCE BINGER

Renovation and Repair (\$110,000) Key projects include installing a new roof, refurbishing eight bedrooms, facility repair, and interior and exterior painting. CORP believes that a well-maintained facility is vital to the experience of our guests and to the economic security of the organization.

The Complete Retreat (\$25,000) Funds are earmarked for research, writing, and production of this book/manual on the history, design, and development of The Retreat model. Together with ancillary lecture/promotional materials, *The Complete Retreat* will be designed to help communities

who are interested in replicating The Retreat model.

Scholarship Funding (\$50,000) These funds ensure that Retreat services remain accessible to individuals who are in need of residential services and who have been economically devastated by their addiction. Each gift is matched dollar for dollar by H.E.A.R.T.

Research/Outcome Studies (\$10,000) Six- and twelve-month outcome studies are conducted by Herbert and Louis, an independent research firm who are tracking and measuring the quality of recovery of our guests. This information helps us to evaluate the effectiveness of our services and to identify who we are best serving.

A New data base system (\$5,000) will enable staff to maintain a database of guests and friends more cost effectively and efficiently.

Sober Living Residences (\$50,000). These funds are earmarked to pay down the mortgage on our Summit Avenue Sober Living Residence. A reduction in current monthly payments will allow us to maintain affordable housing for those in early sobriety.

We recognize that The Retreat succeeds because of its partnerships with people, communities, and organizations who are aligned with our mission and vision. These include our many generous contributors—individuals who have helped us realize our accomplishments and work through our challenges.

As you read our newsletter and become more familiar with our work and services, we hope that in the months ahead you will continue to find The Retreat worthy of your financial support.

RECEIVE RETREAT NEWS UPDATES VIA EMAIL

We are trying to stay in closer touch with The Retreat community via email, and we're working to compile a list of email addresses to enable us to do this. If you would like to receive news about The Retreat—reminders and updates on upcoming Retreat events, project updates, and other current news, just fill out and mail the response envelope, including your email address in the space provided. You may also call The Retreat and give your email address to one of our office staff members. Please let that person know you'd like to receive email updates.



Kevin C.'s journey into recovery included a number of stops and starts along with a few detours. It began with four treatment stays at Hazelden and three months in its Fellowship Club. In spring 2000, Kevin began the first of four stays at The Retreat including one of only four days. Finally, in August of 2001, after telling Retreat staff that he'd do "whatever I have to do to stay sober," Kevin completed 28 days at The Retreat. At the suggestion of The Retreat staff, he then spent 90 days at Progress Valley [a halfway house in Minneapolis]. He then moved into one of The Retreat's sober living residences, where he lived for 10 months. Kevin, who's now more than a year sober, talks about what he gained during his time at the residence and the role that experience plays in his life today.

The Retreat, the Residence . . . the whole program helped me and the others become part of a very supportive, very helpful community. I finally realized that we all need a community of people to recover. I also discovered that people want to—and will—help, but only if you're open to it. In the past, I'd always isolated myself when things got difficult, thinking that no one was interested in my problems. That, of course, only led to more drinking and using. When it came time for me to leave the Residence, I knew I shouldn't live alone, and I'm now living with two guys I met there. I am also very fortunate to have parents who are strong believers in recovery. They've never lost faith in me, and without their support, my journey could have been much different.

The patterns I developed at the Residence have stayed with me because I stayed there until I felt they were strong enough that I really could live them "outside." Today, I typically attend five meetings a week and meet weekly with

A JOURNEY INTO RECOVERY

THE SOBER LIVING RESIDENCE experience was crucial to my progress in recovery. To begin with, it provided one more safe stop before I had to be truly on my own. I knew I still needed help structuring my life, and at the Residence, there was enough to support me, but not so much to eliminate the possibility of relapse. The structure within which we lived—working 30-40 hours a week, attending four meetings each week, meeting with a sponsor, and fulfilling a service commitment, for example—was just what I needed at the time.

I knew that the program could work, but even at this point, I still doubted it could work for me because I'd failed so many times. Thanks to my sponsor, the meetings, and doing service, I began to see results. I finally realized that you had to do a little work to see the benefits! And because I began to see that the work helped, I was able to strengthen the pattern of sober living I had begun to form at The Retreat.

The guys in the Residence and I shared a common purpose: we were each ready to do whatever it took to stay sober. We saw one another living the program and we couldn't help but get involved—it became a collective effort. Most of those guys have now celebrated a year of sobriety and are on to bigger and better things—and that's miraculous because before they came to the Retreat, they couldn't put together even one sober day.

I'd gone to A.A. meetings before I came to The Retreat, but I was always an outsider looking in. I knew A.A. had to be a part of my life and that I had to be an insider to make it work. My time at the Residence allowed me to finally experience A.A. from the inside, and once that happened, I caught fire.

I'VE FINALLY REALIZED
THAT IF WE MAKE THE
CHANGE, OUR PAST
CAN BECOME OUR
GREATEST ASSET.

my sponsor. I attend a Big Book study each week at the Residence because it helps me to stay connected. In addition, I'm the secretary for my home group, and I bring a meeting to the Stillwater prison and The Retreat. And I've volunteered to help organize a fundraising event for The Retreat this year.

This is all such a change for me. For a very long time, I was so involved in myself. Even after I got into recovery, I still wondered why I had to do all this. But during my time at the Residence, I began to see the other side. To help someone else, to see people grow from an experience I've had—well, that was completely new for me. I've finally realized that if we make the change, our past *can* become our greatest asset.

Today, I feel a responsibility to give back to others. I'm focused on others more than on myself. I know how important people were to me, and now I want to be the one who's there with a handshake and help for that new person coming through the door. I actually have two sponsors now, and I take that responsibility very seriously. I'm responsible in ways I never thought possible—and it feels good to have it. People actually call *me* for help, which is amazing. I certainly wasn't getting phone calls like that two years ago! People were staying away from me in droves! For me to be the guy others would turn to for help—that was just unimaginable.

Perhaps the most important thing I realized while living in the Residence is that this is a spiritual path and that you have to trust it and take the jump or recovery won't happen. I had absolutely no idea what it was like to live sanely or to have direction in my life. These things were just never possible. But now they are, and it's just so good to be sober.

The RETREAT *perspectives*

Spring & Summer 2002

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For comments or information about The Retreat,
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FROM THE PRESIDENT

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be to keep the essence of what makes The Retreat unique and effective while expanding the model into new locations. It is essential that we maintain the intimacy and personal nature of the relationships that make The Retreat environment so special.

Why must they suffer

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one which tragically will be interpreted by researchers as additional proof that "treatment doesn't work."

Many years ago, Karl Jung described alcoholism as a "spiritual disease." The history and success of Alcoholics Anonymous adds considerable credence to his claim. Recent outcome studies reveal that programs based on the philosophy and spirituality of Alcoholics Anonymous show recovery rates equal to or greater than programs that are cognitive or psychiatric-based. Today we need to change how we view this disease and to develop treatment/recovery strategies that encompass the entire person—body, mind, and spirit.

How can the recovering community best respond to this situation? By addressing one key cause of the problem: our "deadly silence." When people complete a treatment program and return to family, work, and community, they are often *very* reluctant to talk about their experiences with addiction or, more importantly, with recovery. This silence helps keep public attitudes at the current level of prejudice and ignorance. I encourage those in recovery to begin fully informing family, friends, employers, community organizations, and faith communities about how recovery has changed their lives for the better *and* positively affected the lives of people around them. *In keeping with the Traditions of A.A., we are not, however, asking individuals to publicly represent themselves as members of Alcoholics Anonymous.* Such "teaching by example" will do more to change public attitudes about addiction than lobbying Congress or passing new regulatory legislation. What's more, it is a step *every* recovering person can take.

GEORGE MANN *is one of The Retreat's founders and currently Chair of the Board of Directors.*

Imagine a cool fall evening filled with warmth and goodwill amidst friends and new acquaintances.

Imagine an atmosphere alive with jovial voices, intriguing conversation, mouth-watering aromas, and sweet music.

Imagine a captivating evening filled with excitement and surprise.

Imagine an evening in celebration of The Retreat.

Imagine a life being saved with funds you and others raise for guest scholarships to The Retreat.

Imagine what one can accomplish with a life in recovery.

Imagine being there, being part of it all!


Imagination becomes Reality

September 13, 2003
The Circus Juventas circus school/tent
Highland Park
St. Paul, Minnesota

You will not want to miss this
remarkable event.

Watch for more information!