The Intersection Between Recovery Capital and Authentic Leadership

by Melissa Silvey

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TIME SUBMITTED	09-JUN-2019 04:25PM (UTC-0400)	WORD COUNT	9791
SUBMISSION ID	1141715970	CHARACTER COUNT	52132

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Acknowledgments

I wish to thank each professor at Granite State College that provided leadership, mentored me through course, and is genuinely in education for the students.

I wish to thank my advisor, Kathy DesRoches, for always talking me down of the self-imposed cliff before the start of every class I took at Granite State College.

I want to thank friends and colleagues who supported me and encouraged me to go back to school after 20 years to get my masters- especially my friend and mentor Lisa.

Lastly, my only child Emma, is graduating High School while I graduate with my Masters. She took the brunt of the additional schoolwork on nights and weekends, spending less time with her. We both are achieving milestones that will not be understood right away but will be for years to come.

Abstract

Authentic Leadership shares characteristics and traits with individuals who are in recovery from a substance use disorder and works towards building Recovery Capital. Leadership roles have been new to the recovery field, in order to impact policies in the local, state, and federal space due to the ongoing public health crisis of opioid use disorders overdoses and deaths. We see many step out of their role of maintaining their anonymity into the public space to provide leadership related to decreasing the number of deaths related to opioid use in America. These new leadership roles align with Authentic Leadership traits and work to build Recovery Capital, based on Social Capital principles. The three topics intersect in this paper but continue to be siloed in the literature. This study seeks to draw the three topics together for future study and review. Leadership is at the heart of sobriety and Recovery Capital.

Introduction

"Addiction professionals across America are witnessing the field's paradigmatic shift from a pathology and intervention focus to a recovery focus (White, 2004, 2005)."

NH has been at the forefront of an opioid epidemic. It also has some of the highest alcohol consumption rates and binge drinking rates in the country. According to NH Drug Monitoring Initiative (2018), in 2016, NH had 485 deaths; 2017 showed a slight increase with 488 deaths and 2018 reported a dramatic decrease to 364 deaths. The NH Drug Monitoring Initiative (2018) reported that life-saving naloxone (Narcan) had 5,000 units distributed throughout the state in 2016-2017, and an additional 5,000 units were distributed in 2018. The naloxone administration by EMT's in NH in 2016 was 2,895; 2017 was 2,774, and 2018 was 2,234 as reported in the NH Drug Monitoring Initiative (2018). Naloxone is a lifesaving drug that is usually inexpensive, but as the epidemic got worse, the price for naloxone jumped dramatically. The state is flooded with naloxone as one tool in its tools in the toolbox of addiction and death.

In 2013, the National Survey on Drug Abuse and Health (NSDUH) data revealed that 8.22% had used illicit drugs, compared to the US rate of 7%. Those in the 12-17 age group reported 4.21% use of non-medical prescription drugs compared to 3.65% of New England states. Moreover, 18-25-year-old who used prescription drugs within the past year was 9.8% in 2014, and the national statistics revealed 8.3%.

Understanding how leadership can have an impact on substance use disorder, this review seeks to draw attention to authentic leadership and individuals who have been trained as recovery coaches. Another aspect of this review seeks to see how researchers have identified recovery, recovery capital, and authentic leadership. Multiple researchers disagree on terminology,

definition, and actions. Authentic leadership closely aligns with recovery coaches also known as offering peer recovery support services (PRSS), and when reviewing data from the authentic leadership scale will demonstrate particular characteristics that align with PRSS (Recovery Coaches) using Authentic Leadership traits.

Literature Review

A review of many leadership styles reveals that authentic leadership aligns closely with the constructs of recovery capital and characteristics of people in recovery from substance misuse or substance use disorder (SUD). This literature review seeks to ask the question of whether those in recovery have a leadership style aligned with authentic leadership. To date, there has been no journal articles or other material that incorporates a leadership style with recovery capital and characteristics of those in long term recovery or those who have graduated from a Recovery Coaching framework. This review will incorporate journal articles, newspaper articles, recovery coaching curriculums, survey data, qualitative data and other artifacts related that synthesize authentic leadership, recovery capital, and leadership style of persons in recovery from a substance use disorder and allies; defined as supporters of someone with a SUD.

This literature review also has a policy focus which has primarily been around opioids within the past decade. This includes the prevention of drug overdoses of individuals experiencing Opioid Use Disorder (OUD). Despite more robust scientific research into addiction, even less research is available that assesses long-term recovery and quality of life. For those who stay in recovery, there is even less understood due to a lack of research. The public policy response has been reactive and aimed at public health outcomes, often compared to the science of medical and public health interventions (Brown & Ashford, 2018).

Recovery capital aligns with Authentic Leadership, so this review will have a concentration on aligning the constructs of recovery, long-term people in recovery, recovery capital, and authentic leadership. Data collected shows that people in recovery and allies who have gone through training such as Recovery Coaching Academy and Recovery Coaching Ethics (optional) have traits that align with authentic leadership and have often used those traits to impact policy on a local, state and federal level to make an impact on the OUD crisis.

Recovery from Alcohol and Other Drugs

Drug and alcohol abuse are devastating problems with enormous social and economic consequences. Lost employment and productivity, disrupted families and family violence, health difficulties, criminal behavior, and motor-vehicle injury and fatalities are but some of the sequelae of drug and alcohol misuse, which has been estimated to cost the United States over $240 billion per year (Harwood, 2000).

Many articles can have been identified that addresses recovery from mood- and mind-altering drugs and defining persons in recovery; this literature review acknowledges three definitions of recovery. "Often lost in this response is the pursuit of sustainable, long-term solutions that allow for an individual with a SUD to reconstitute their lives in a comprehensive and meaningful way (Brown & Ashford, 2018)." Over the decades, addiction specialists have been providing screening and assessment instruments that evaluate problem severity, complexity, and chronicity, but offer little data on internal and external resources individuals and families can mobilize in resolving such problems (White & Cloud, 2008, as cited in Best, Edwards, Cano, Durrance, Leham & White 2018).

Another acknowledgment of a lack of cohesive definitions came from the Betty Ford Institute Consensus Panel (2007) which acknowledges "although widely used, the lack of a

standard definition for this term has hindered public understanding and research on the topic that might foster more and better recovery-oriented interventions." However, a recovery definition was developed and adopted from the panel. The panels working definition of recovery is defined as "a voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship (Betty Ford Institute Consensus Panel, 2007)."

Witbrodt, Borkman, Stunz, and Kaskutas (2016) have two working recovery definitions because related to those seeking recovery and those seeking recovery through multiple pathways. They acknowledge that the recovery field has a medical definition, which involves abstinence from all mood- and mind-altering drugs and alcohol; while another definition has emerged regarding recovery using multiple pathways (Witbrodt et al., 2016). The medical viewpoint reported in this article recovery is actually achieved at the end; diagnosis, treatment, and rehabilitation all come before recovery. Multiple pathways refer to the various ways (medication or various mutual aid groups) to obtain recovery and its client-centered.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT) convened a substance abuse treatment and recovery individuals to a national summit and had 100 people attend at which treatment and recovery silos often did not work together (2005). The summit conference report revealed a new working definition of recovery for the field of treatment and recovery. "Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life (Cotter, 2005)."

More work from the SAMHSA/CAST Summit (2005) developed the following snapshot of guiding principles of recovery from addiction includes there are many pathways to recovery;

recovery is self-directed and empowering; recovery involves a personal recognition of the need for change and transformation; recovery is holistic; recovery has cultural dimensions; recovery exists on a continuum of improved health and wellness; recovery emerges hope and gratitude; recovery involves a process of healing and self-redefinition; recovery involves addressing discrimination and transcending shame and stigma and lastly recovery is supported by peers and allies (Cotter, 2005).

Multiple definitions of recovery prevail in the field, and there is no one definition of recovery that is agreed upon by the treatment and recovery field. The person stuck in the middle is the client, who has medical recovery that was not available 5-10 years ago, and that client has been denied treatment opportunities and residential treatment because they are taking medication to manage opioid use, alcohol use or methamphetamine use.

While SAMHSA/CAST provided for the summit in 2005, they did not intervene with grant changes and funding matrix to change treatment programs; moving them away from an acute care model of abstinence-only and avoiding dually diagnosed clients (mental health diagnosis coupled with substance use disorder). Another definition of recovery offered by Best & Laudet (2010) is "recovery is a process rather than an end state, with the goal being an ongoing quest for a better life."

Lastly, as peer support recovery began to take hold in the last decade, another reference for recovery came from Brown and Ashford (2019) and it states, "recovery is an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness." While there is no singularly held definition of recovery, all of the literature reviewed on recovery show thoughtful leadership that mimics authentic leadership. Based on the research, the

definition of recovery is not agreed upon by many, and there are a variety of mutual aid, medication, and recovery frameworks that are too large to report here. While defining recovery is widespread, working within a Recovery Capital construct is difficult as laid out.

Constructs of Recovery Capital

A review of ten journal articles was reviewed to define Recovery Capital (RC) in addition to the qualities, traits, and characteristics that would align with an emerging leadership style, Authentic Leadership. Recovery capital is defined by the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe Alcohol and Other Drugs (AOD) problems (Granfield & Cloud, 1999; Cloud & Granfield, 2004). In Cotter's 2009 review of Recovery-Oriented Systems of Care, the Culture of Recovery and Recovery Support Services, there are 17 aspects of a recovery-oriented system which cross over to the Assessment of Recovery Capitals 50 question instrument. Moreover, "mutual aid or peer support groups have been shown to play a significant role in the *process* of recovery (Cotter, 2009)."

In a literature review of recovery capital, Hennessy (2017) uses the same definition of recovery as the Betty Ford Institute Consensus Panel (2007). Hennessy also shares that recovery capital's theoretical foundations which arose from previous literature have not had a systematic review sought to identify and synthesize recovery capital literature before her work in this literature review. Domains of recovery were initially researched by and the ecological framework which included micro (social and family/social recovery), meso (cultural and community recovery) and macro (physical, human, personal recovery/health, and growth) levels and identified types of capital: physical, human, and social capital developed by Granfield and Cloud (1999) and included in the literature review (Hennessy, 2017).

Granfield and Cloud (2004, 2008) updated their definition of recovery capital to include social, physical, human, and cultural capital that made up the definition of recovery capital. Recovery capital (RC) is a direct descendant of Robert Putnam's groundbreaking research into the disconnection we feel like a country and how we are leaving social networks highlighted in Bowling Alone (2001) which identified social capital as "that social networks have value. Social capital refers to the collective value of all "social networks" [who people know] and the inclinations that arise from these networks to do things for each other ["norms of reciprocity"] (Putnam, 2017)."

Putnam's research discusses the need for connection in such a disconnected world. Persons with SUD need to find a way to feel fulfilled in replacement of drugs and alcohol. This might be why 12 step recovery programs provide the socialization and identification SUD person's need on an ongoing basis.

Robert Putnam (2001) developed the term 'social capital' which emphasizes not just warm and cuddly feelings, but a wide variety of quite specific benefits that flow from the trust, reciprocity, information, and cooperation associated with social networks. Social capital creates value for the people who are connected and – at least sometimes – for bystanders as well. Social capital can be found in friendship networks, neighborhoods, churches, schools, bridge clubs, civic associations, and even bars.

The motto in Cheers, "where everybody knows your name" captures a critical aspect of social capital. Since Putnam was the father of social capital, several pieces of literature utilized his initial approach of disconnection, the need to have connections to networks of people in recovery and connection to areas such as housing, employment, and family supports all tie into

greater lengths of sustained sobriety. The more one is connected to networks, the better the outcomes will be when studying recovery capital or working with those new to recovery. It's imperative to connect them to a network; it is a protective factor for early sobriety and long-term sobriety.

William White and William Cloud (2008) presented Recovery Capital as the following three domains:

Personal recovery capital can be divided into physical and human capital. A client's physical recovery capital includes physical health, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Human recovery capital includes a client's values, knowledge, educational/vocational skills and credentials, problem solving capacities, self-awareness, self-esteem, self-efficacy (self-confidence in managing high risk situations), hopefulness/optimism, perception of one's past/present/future, sense of meaning and purpose in life, and interpersonal skills (White & Cloud, 2008).

Family/social recovery capital encompasses intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., a family of choice), and social relationships that are supportive of recovery efforts. Family/social recovery capital is indicated by the willingness of intimate partners and family members to participate in treatment, the presence of others in recovery within the family and social network, access to sober outlets for sobriety-based fellowship/leisure, and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations) (White & Cloud, 2008).

Community recovery capital encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug problems (White & Cloud, 2008). Each instrument and definition presented in the Recovery Capital portion of this Literature Review has grown upon the previous version, and not all authors agree on the theoretical frameworks of Recovery Capital.

Constructs of Authentic Leadership

Authenticity occurs when an individual aligns personal values and action (DeLauer, 2012). Authentic leadership was introduced as a style developed by Shamir and Eilam (2005) and disseminated in Leadership Quarterly. The field of leadership has referred to this style as one adapted from transformational leadership. Authentic leaders are described as high on moral character and those who are "deeply aware of how they think and behave and are perceived by others as being aware of their own and others' values/moral perspectives, knowledge, and strengths (Avolio, Gardner, Walumbwa, Luthans, & May 2004)."

Authentic leadership is seen as a positive form of leadership that has roots in transformational, ethical, charismatic, and servant leadership (Covelli & 2018). Shamir and Eilam (2005) describe authentic leaders 'which are portrayed as possessing self-knowledge and a personal point of view, which reflects clarity about their values and convictions.'

Avolio and Gardner (2005) identified the following dimensions of authentic leadership: *positive moral perspective, self-awareness, balanced processing, relational transparency, positive psychological capital, and authentic behavior*. Also, authentic leadership has a strong developmental focus in terms of both moral developments of the leader and the developments of authenticity in followers.

Shamir and Eilam (2005) summarized authentic leadership as:

1. Authentic leaders do not fake their leadership. They do not pretend to be leaders just because they are in a leadership position. Self-authenticity is critical to authentic leadership.
2. Authentic leaders do not take on a leadership role or engage in leadership activities for status, honor, or other personal rewards; they lead from conviction. That means who they lead holds the real power
3. Authentic leaders are originals, not copies. Finding this is done through self-awareness.
4. Authentic leaders are leaders whose actions are based on their value and convictions. What leaders say is consistent with what they believe. This can be considered to be 'walk the walk, talk the talk.'

Another article (Taylor, 2012) describes the characteristics of authentic leadership; Self-awareness topped the list followed by leading with heart, focusing on long term results, integrity, leading with vision, practice excellent listening skills, transparency, consistency, shares success with their team and draws on experiences.

Development of Authentic Leaders

Covelli (2018) uses the definition of Authentic Leaders from a developmental approach created by Avolio & Gardner (2005) definition. She references the initial Gallup Leadership Institute 2004 as the pinnacle in authentic leadership, with over 250 scholars, business leaders, undergraduate, and graduate students were the primary voice of the then developing authentic leadership and producing higher organizational outcomes. The Avolio & Gardner (2005) model

of authentic leadership is the most common approach referred to, and relies on four areas of balance:

1. Self-Awareness
2. Self-Regulation (or internalized moral perspective)
3. Balanced processing
4. Relational transparency

Shamir & Eilam theorized in Leadership Quarterly (2005) and the Gallup Leadership Institute that leaders' authenticity relies heavily on the meaning that the leader attaches to his or her life experiences. They also argue that leaders' authenticity can be measured to the fidelity of their actions and thoughts to the meanings they create by their life stories.

The Intersection Between Recovery Capital and Authentic Leadership

Shamir & Eilam theorized in Leadership Quarterly (2005) along with the Gallup Leadership Institute that leaders' authenticity relies heavily on the meaning that the leader attaches to his or her life experiences. They also argue that leaders' authenticity can be measured to the fidelity of their actions and thoughts to the meanings they create by their life stories. This is where is an intersection between Authentic Leadership, Recovery and Recovery Capital are converging together towards an authentic self who can share their stories as a way to build trust and let followers know there is an alignment between the leader's stories and the follower's stories.

This is where they learned to tell their own story and keep with the model's number one tenet; people are in recovery when they say they are, and a close second, we respect as Recovery Coaches that there are multiple pathways to sobriety. Some of the new recovery pathways may

include a medication model, 12-step abstinence model, SMART Recovery model which is steeped in Cognitive Behavioral Therapy (CBT), and other methods such as a Buddhist model known as Refuge Recovery. Between authentic leadership as a developmental framework, its crosswalk with those surveyed after three years since they took the Recovery Coaching Academy demonstrated outcomes in area core values of authentic leadership among Recovery Coaches.

Framework for Analysis

As demonstrated through this literature review, there is currently no literature that draws from authentic leadership and recovery capital together. While there needs to be an understanding of how leadership can have an impact on substance use disorder, this review drew attention to the definition and characteristics of authentic leadership. This review identified what recovery coaches were and drew from the literature the purported characteristics and traits of a recovery coach. This review also sought to include multiple definitions of recovery capital, which demonstrated that there is no one accepted definition or framework that subject matter experts are working within.

This literature review provided supposition that Authentic Leadership has aspects that closely align with recovery capital. Another aspect of this review sought to see if analysis existed in using the Authentic Leadership Questionnaire as a way to measure leadership traits but also use to measure closely aligned recovery capital traits. More research is provided in the methods section of this paper. One clear understanding gained was that recovery, recovery capital, authentic leadership, and their intersections have not been reviewed or identified through this review, and it should be noted that multiple researchers disagree on terminology, definition, and analysis.

Because each discipline has their own literature, it is imperative that this paper looks at the siloed body of work and seeks ways to tie together the characteristics and traits of an authentic leader, who has recovery capital and sobriety of their understanding. To be an excellent recovery coach requires self-awareness, healthy boundaries, understand their strengths and weaknesses when working with recoveree. Authentic leadership draws from similar traits and characteristics, and both areas of research reveal there is more research to be done.

Methods

Mixed Methods*:* This paper used a mixed method approach, collecting both quantitative and qualitative data. Below are the methods used for each approach of the analysis and data collection design.

Quantitative. The methods portion of this literature review includes an implemented 16 question Authentic Leadership Questionnaire implemented using Qualtrics had (N=33) respondents who participated in a Recovery Coaching Academy, using the prescribed curriculum in 2016 for 30 hours of training. The ALQ was administered in a closed Facebook group of Recovery Coaching graduates and survey results were collected in late May and early June 2019. This study did not ask whether they were using their skills gained in the Recovery Coaching Academy. There was a 100% response rate.

The IRB reviewed and approved the study design consisting of surveying in a closed Facebook group on May 23rd, 2019. Directions were given to participants that included a disclaimer that none of the questions would bring harm to any subject that completed the survey, but if participants felt uncomfortable by any of the questions, they could merely X out of the survey and not have their data studied.

Qualitative interviews.

Two qualitative interviews were set up with individuals who were male, and one had seven years sobriety, the other had twenty-five years of sobriety. Their recovery was very public, so there was a desire to measure qualitatively their sobriety; which is akin to developmental milestones. The two interviews took place in May 2019. Both individuals were given a disclaimer added by the IRB that if any of the questions were of a triggering nature, the interview would stop immediately. There were no concerns from the two subjects. One interview was done in person using a tape-recorded interview (phone) process and one was done over Skype, also using a tape-recorded device(phone).

Analysis/Results

Quantitative Data

The response to the Authentic Leadership Questionnaire (ALQ) is designed to measure the characteristics that comprise Authentic Leadership (Walumbwa, Avolio, Gardner, Wernsing & Peterson, 2008). From that survey, it solidified that there is a correlation towards some traits that are identified in Authentic Leadership literature and Recovery Capital literature using mixed methods (Witbrodt, Borkman, Stunz, & Subbaraman, 2014).

The ALQ contained different dimensions of the measurement of authentic leadership traits, but cross-tabulated analysis of the four components (self-awareness, internalized moral perspective, balanced processing, and relational transparency) was not done, however, cross tabulation did occur using gender. The reason for this was the accelerated pace of Capstone 850 schedule and deliverables.

Individuals who took the ALQ in its entirety and only 10 men responded and 23 women. The rating scale ranged from strongly disagree being 1, being neutral-3, and strongly agree is 5. When analyzing the data for cross-tabulation of male and female responses, it was noted that 2 males reported neutral and no females, which caused CHI Square and could be deemed inaccurate.

The full graphed ALQ is located in Appendix B. Some highlights, and interesting data from the survey is illustrated below:

		Gender		
		Male	Female	Total
My actions reflect my core values	Strongly Agree	3	7	10
	Agree	5	15	20
	Neutral	2	0	2
	Disagree	0	1	1
	Strongly disagree	0	0	0
	Total	10	23	33

(Table 1-Question 5 of ALQ Cross-tabulated by male and female)

		Gender
My actions reflect my core values	Chi Square	5.30*
	Degrees of Freedom	4
	p-value	0.26

**Note: The Chi-Square approximation may be inaccurate - expected frequency less than 5.*

(Table 2-cross tabulation male and female CHI-Square of question 5)

On question 17, a similar CHI Square of 7.15 was reported as illustrated below. 2 males were neutral, and no females were neutral.

My morals guide what I do as a leader	Strongly agree	7	13	20
	Agree	1	10	11
	Neutral	2	0	2
	Disagree	0	0	0
	Strongly disagree	0	0	0
	Total	10	23	33

(Table 3-Question 17 of ALQ Cross-tabulated by male and female)

		Gender
My morals guide what I do as a leader	Chi Square	7.15*
	Degrees of Freedom	4
	p-value	0.13

**Note: The Chi-Square approximation may be inaccurate - expected frequency less than 5.*

(Table 4-cross tabulation male and female CHI-Square of question 17)

Other data retrieved from the survey included The author does not have substantial statistically analysis training, but the data in Appendix B is quite impressive when viewed overall as the ALQ. Many reported strongly agree or agree, which means a higher quotient overall demonstrated Authentic Leadership traits and characteristics.

Additional data gleaned from the survey showed that on question 94% of respondents reported that they strongly agree or agree that they can list their 3 greatest weaknesses on Question 4. This demonstrated self-awareness. A surprising result was from question 6, which asked if respondents seek others' opinion before making up their own mind. The 52% were neutral, which demonstrates a balanced processing. Question 8 asked respondents if they can list their three greatest strengths, and 88% agreed or strongly agreed. This demonstrates self-awareness. On Question 10- I listen closely to the ideas of those who disagree with me, 82% agreed or strongly agreed. This demonstrates balanced processing. On Question 11, I let others

know who I truly am as a person, 73% strongly agreed or agreed to this question. This demonstrates relational transparency.

Qualitative Data

Interview questions for persons in recovery from substances for two or more years and played a presumed authentic leadership role in reducing opioid use in NH between 2015-2019 were selected and can be found in its entirety in Appendix C. Shielded from identification, initials of DL and JH are used to report the experiences and responses related to their recovery and the questions touch on aspects of authentic leadership. The full text from their interviews/manuscript are located in Appendix C. Some of the most helpful narratives from the manuscript are found below under each question and identified by initials only.

DL has seven years in recovery and JH has twenty-five years of recovery. Key responses are below:

1. At what point did you realize you needed to take on a leadership role that involved publicly announcing your recovery status in service of efforts to reduce opioid use, overdoses, and related death?

   ~JH~ *I let them know I was a triple threat: a doctor, in recovery and a legislator*

   ~DL~ I saw The Anonymous People when it came out in 2015, and I think that was the catalyst for me jumping into the fray as a person in recovery, whatever that was going to look like.

   ~DL~ a year later I was telling my recovery story in that rehab, and a guy who had just been admitted recognized my story and said it was the reason he decided to go to treatment.

~JH~ *Used my own story related to people having to wait 72 hours to get treatment after I gave my speech, people who did not really like me came and hugged me after. If I had to wait 72 hours, I would have been dead.*

~JH~ *The committee in the House changed their votes based on your personal story, and this was an example of authentic leadership.*

2. As a person in recovery or ally, did you feel like it was your purpose to work on building recovery capital when the opioid crisis started to develop in NH? If yes, what do you think is the most important milestone that you were involved in achieving?

~DL~ *I stopped using just before fentanyl started replacing heroin in NH. I was successful with the prevalent and prescribed 12-step treatment and recovery model.*

~JH~ *Worked to build recovery capital. Able to testify, "Said Hi, I am Joe, and I am a Recovering Legislator." Most legislators in the room did not get the joke, as it is mimicked after an AA meeting.*

~DL~ *Since Day One in my recovery, I've been watching many equally deserving people have doors closed on them, and many of them die, cycle between jail and probation, or just struggle to find the stability that I've enjoyed as a model of privilege in recovery. So yes, guilt and general concern and a pre-existing social justice bent solidified my sense of purpose in recovery as centering around creating more inroads to stability for those with less privilege.*

~JH~ *Getting the Naloxone bill and the Good Samaritan Bill passed, being given a voice of recovery, that guy well dressed, showed up in a suit. Syringe bill was a huge milestone.*

~DL~ *I think the milestone that I was involved in that I'm most proud of was the launch of the first sustaining, above-ground syringe services program in NH.*

~JH~ *Leadership is about having others take the lead when you aren't there, and I do nothing expecting to be there forever. Not married to any of my projects. There is emotional attachment to some.*

3. How did you practice self-care when your day's work was related to overdoses and death of community members?

   ~DL~ *I think in part the traumas that influence my addiction serve to protect me against burnout or spiraling grief. I learned to detach from pain and today, that means I generally don't process painful news or experience in real time, if at all.*

   ~JH~ *Having a healthcare background has allowed me to detach. We were trained for that. Even if I can't fix the problem, I still did something.*

   ~JH~ *For everyone you hear about (died, OD, slipped) there are a bunch you do not hear about. There is a ripple effect; every little thing you do leads to a change. You made a change or took a step, simply saying hello to a homeless person, or reach out to someone who is suicidal, most ignore, how are you doing, its humanizing, littlest of change.*

   ~DL~*I can't find just self-care my way into wellness. That was apparent during week two in treatment when I found I had something to offer a new guy who was struggling, and that my helping him literally kept me in treatment.*

4. Did/do you feel that your personal recovery or wellness is separate from the work that you did/do in helping others to initiate and sustain their recovery? If so, how did/do you maintain this separation? If not, please explain your own approach to wellness in your work.

~DL~ *I think the people who are effective in this recovery leadership space have lots of different missions – they are complicated people. But the missions that drive their best work are uncomplicated, unchanging, and developed unconsciously. 'Help people' isn't something you have to think about, and you can't will yourself to feel it more strongly than you do.*

~JH~ You *try to keep personal life separate, but everything you learn or do has an effect on others. My recovery has an effect I learn as much from someone with 30 days, and they don't think that they have anything to give. They don't realize they are helping you, must listen to everyone.*

~DL~ *I'll say that I've never met someone that I identified as an authentic leader that ever did anything to change my mind about whether or not they embodied authentic leadership.*

~JH~ *When someone overdoses, and a kid died recently, Trevor, you've seen him. I asked myself could I do more. Saw Trevor 6-7 months ago, at a political event, Trevor was outside, I asked if he knew where the cafeteria. Why not come in and get the pizza to Trevor. Invited him to get the pizza, 3-4 people from the event were nearby, Trevor was never offered a piece of pizza, was homeless, dirty, with shopping bags, the supporters of the event were so embarrassed. Talked with him in the parking lot, started coming back around, but he died.*

5. How did you go about developing your own personal mission to demonstrate a positive impact during the opioid crisis?

~DL~ *If I have a mission, I suppose it is to improve opportunities for and care of people who are beset by addiction. My understanding of how best to carry that mission out has changed significantly over my 6 years doing 'recovery work.' I think that's appropriate.*

~JH~ *A 19-year-old came up to me after the meeting and said no one told me that I did not have to go back to using. Three weeks, it still stuck with me. Not just doing what I have done, and there are levels of recovery. My mind was changed when I embraced harm reduction.*

~DL~ *Help people' isn't something you have to think about, and you can't will yourself to feel it more strongly than you do. I think someone who is a real leader in this space, with a general mission of 'help people', might negotiate with other missions like 'make money' and 'keep the peace' but doesn't let other missions crowd the main one*

~JH~ *Not my gold standard to have people go from a 12 pack a day to 9, some of the things I have mentioned here are not my greatest achievements, but they took leadership in each example we discussed. Some of the best things were the little things so insignificant but most impact. Make you feel good.*

Discussion/Analysis

One clear understanding gained through this literature review process and research are that recovery from a substance use disorder, recovery capital, authentic leadership, and their intersections have not been reviewed or studied together. The topics are siloed, based on the literature that was identified for this review and utilized. Moreover, through this review, it should be noted that multiple researchers disagree on terminology, traits, characteristics, and analysis using all three subjects of recovery, recovery capital, and authentic leadership. There

did not appear to be any extensive research of peer-reviewed journals and literature reviews that ties the subject matter together.

This study lacked the time needed to be more exhaustive in its research, especially its research using original quantitative and qualitative research. The research aspect commenced in late May and concluded the first week in June. The survey data we received had a phenomenal response rate for a closed group on social media of 100%. The ability to get a high response rate is not surprising because the closed Facebook group is used to get people who present at the hospital, the recovery community organizations and other places into an assessment and treatment process immediately. The assignment of a recovery coach, coordinating transportation makes this groups response time from members very expedient. The qualitative data of interviews only engaged two individuals, but their data is rich, as demonstrated in the qualitative section of the data reported.

Due to time limitations, more interviews could not be completed, written up and coded in such a short span of time. Lastly, the researcher had minimal training in research methods and data collection. Even with years of experience implementing the Youth Risk Behavior Survey over a 10-year span, the surveys were the responsibility of the state and the data reviewed was done by the State and the CDC, so we simply shared and disseminated the results with community members. The researcher for this review had no experience coding or working with an IRB. This was a hindrance of being able to tell a more in-depth, richer story using quantitative and qualitative data.

Conclusions/Recommendations

The topics of addiction, recovery and recovery capital continue to be thoroughly researched as the US invests in national research entities such as Center for Disease Control and Prevention (CDC), National Institute of Health (NIH), National Institute for Drug Addiction (NIDA)country continues to face a public health crisis of opioid use disorders and deaths from overdoses. It also lacks the necessary treatment programs needed to help those in need and in crisis sufficiently.

Every day NH buries at least one adult from an overdose a day and most days its two. With unscrupulous drug cartels getting more and more product into the United States and into New Hampshire, we will continue to lag behind what might be the next epidemic, methamphetamine. There will never be a day that we will not have drugs and alcohol play a role in heartbreak, the question that needs to be asked and answered is why do so many starts in the first place?

Leadership, particularly Authentic Leadership takes courage to have it become part of a person's DNA. It asks us to be self-aware, have the ability to internalize moral perspectives, develop a balanced processing, and relational transparency- all skills not bestowed to someone suffering from addiction. It is when recovery is found, and recovery capital is built, and authentic leadership leads to community, state, and federal change to save lives.

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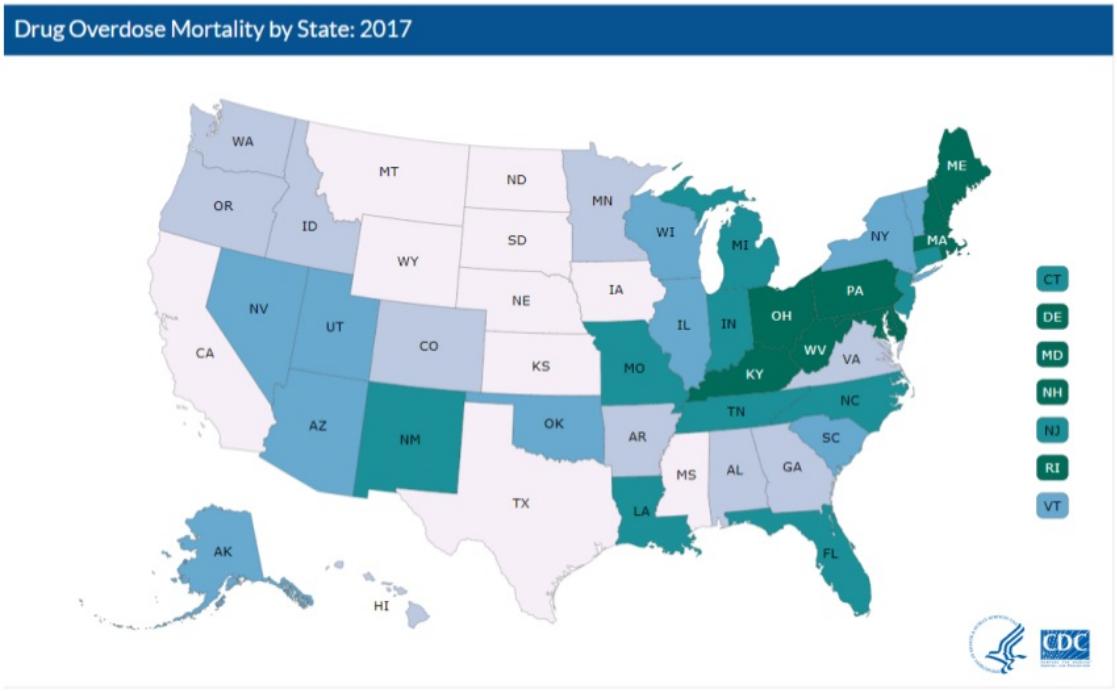
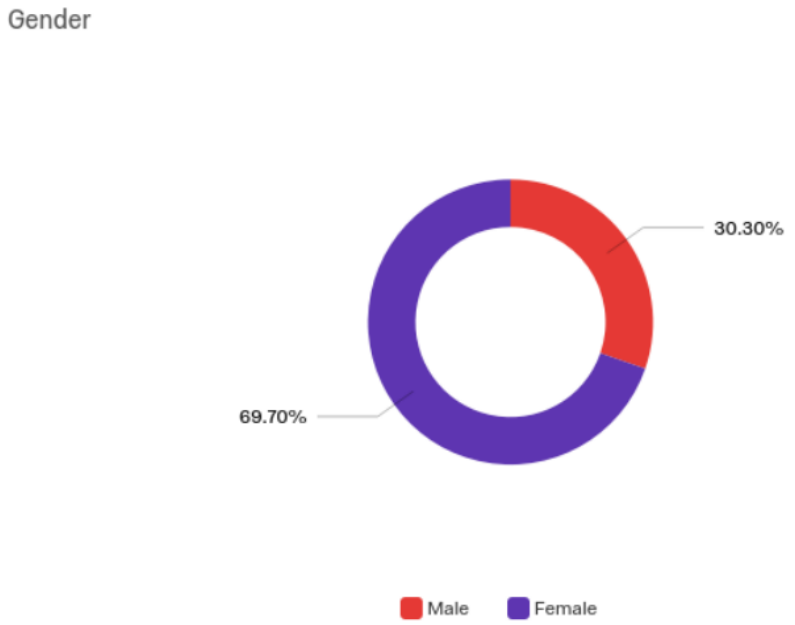
Appendices

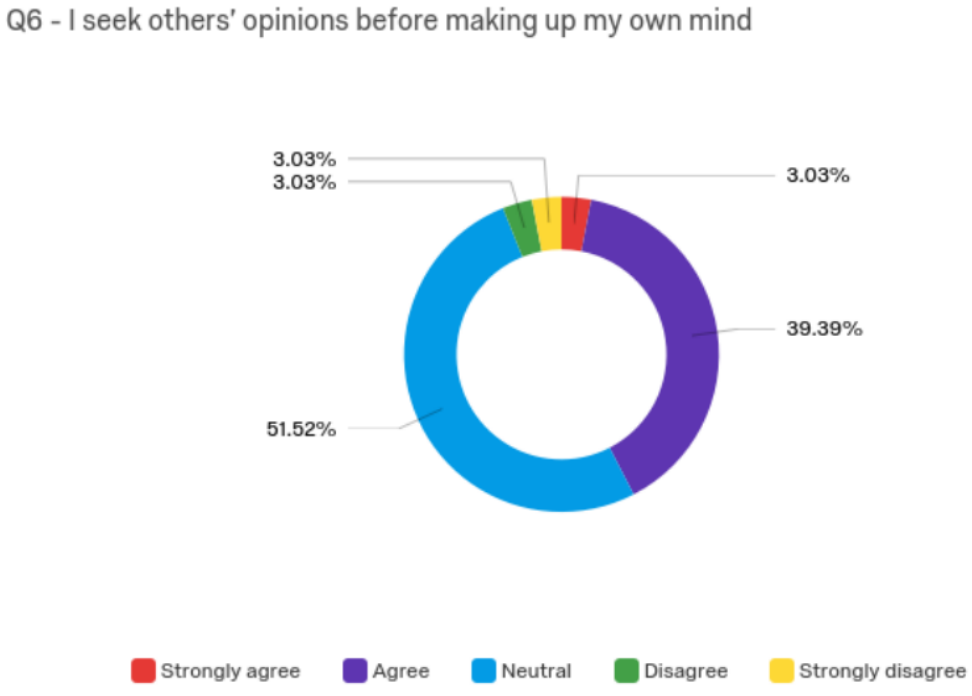
Appendix A CDC Drug Poisoning Mortality by State



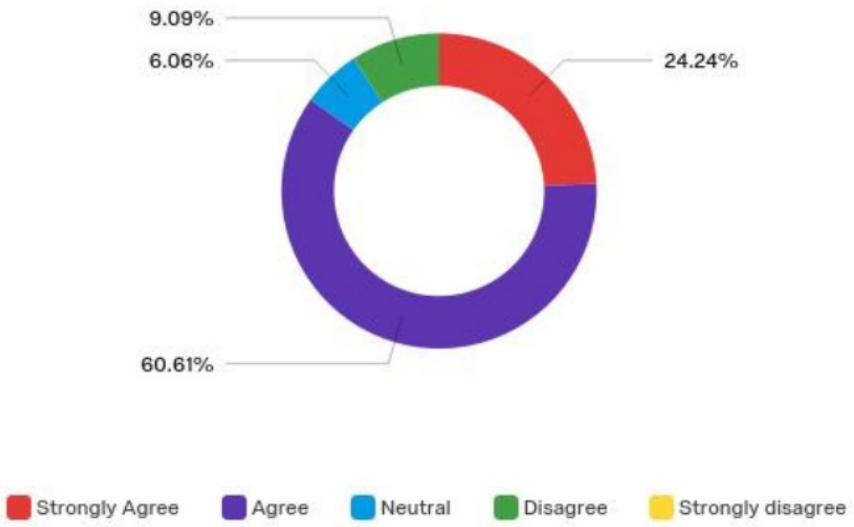
https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

Appendix B-Authentic Leadership Data Outcomes

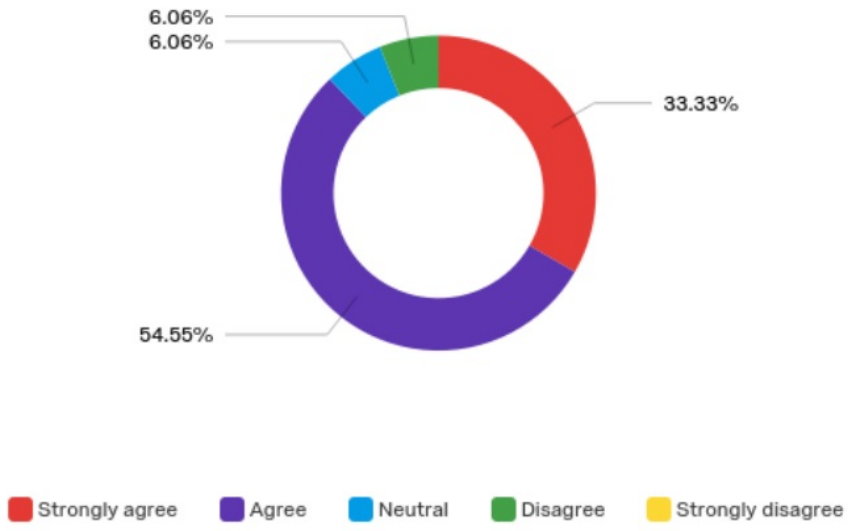




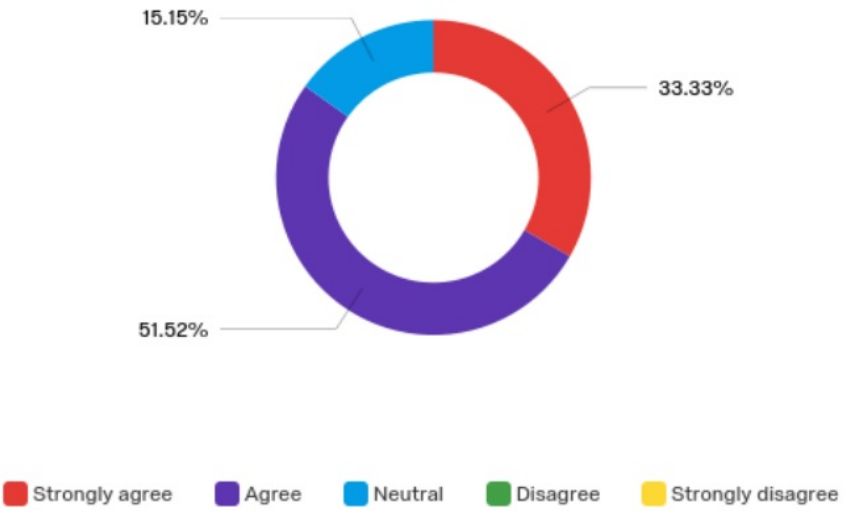
Q7 - I openly share my feelings with others



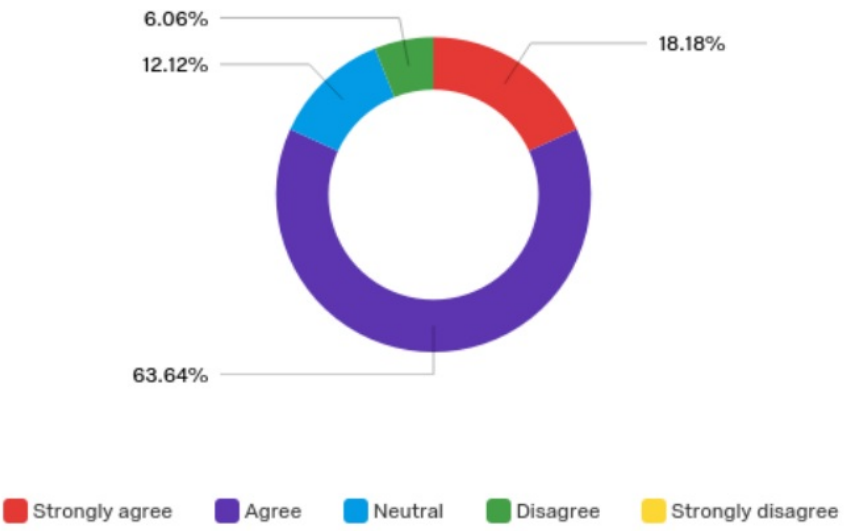
Q8 - I can list my three greatest strengths



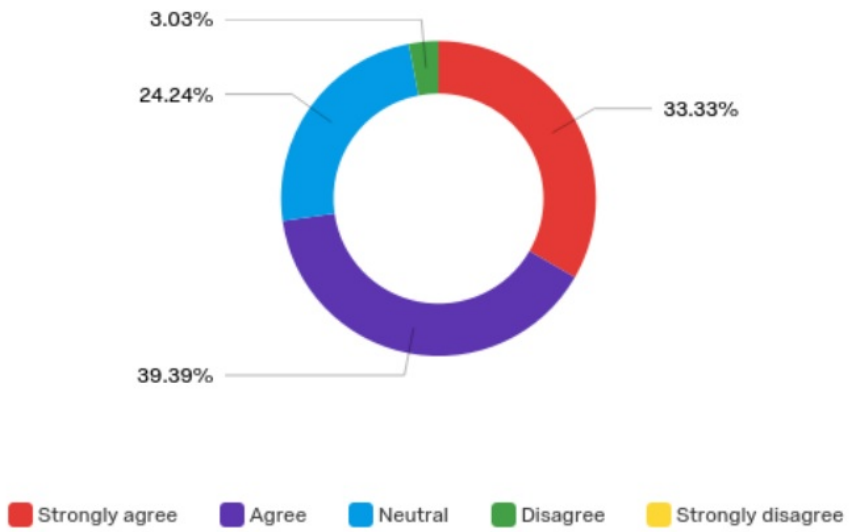
Q9 - I do not allow group pressure to control me



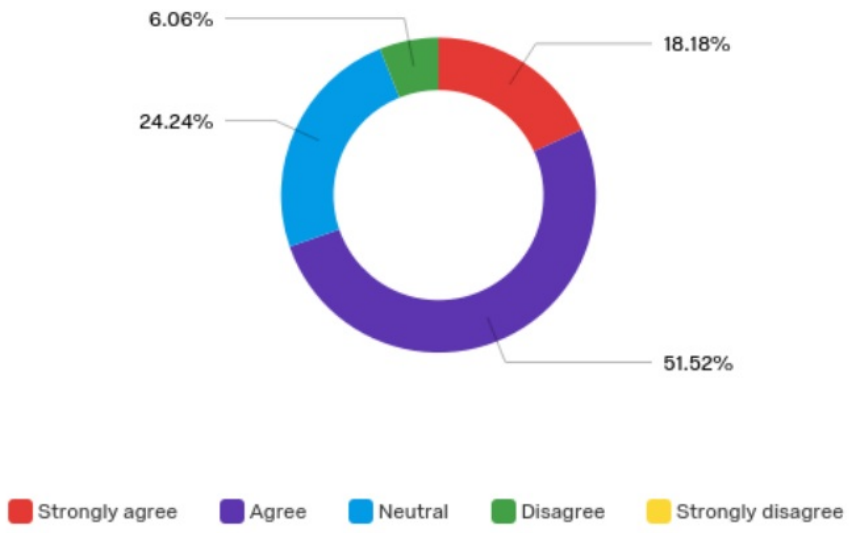
Q10 - I listen closely to the ideas of those who disagree with me



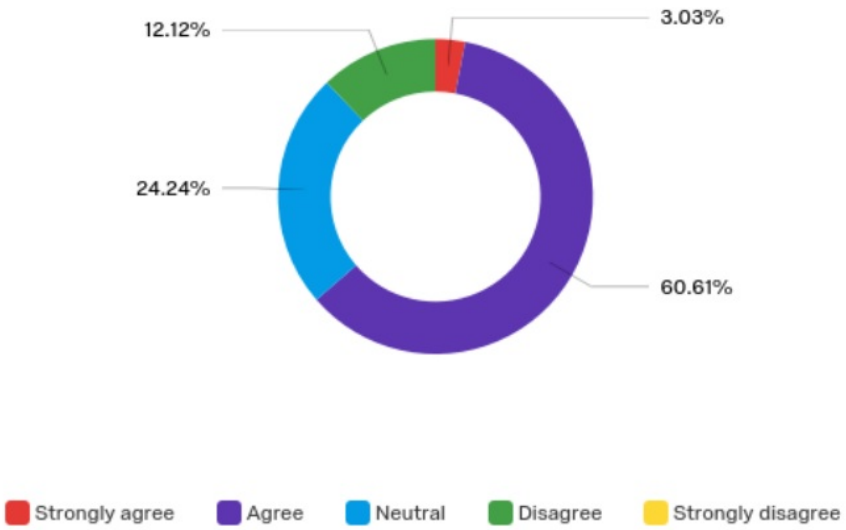
Q11 - I let others know who I truly am as a person



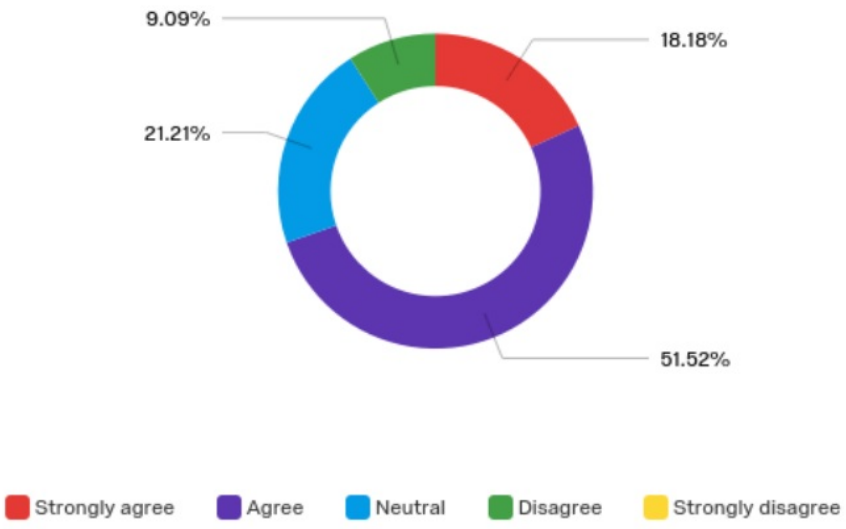
Q12 - I seek feedback as a way of understanding who I really am as a person



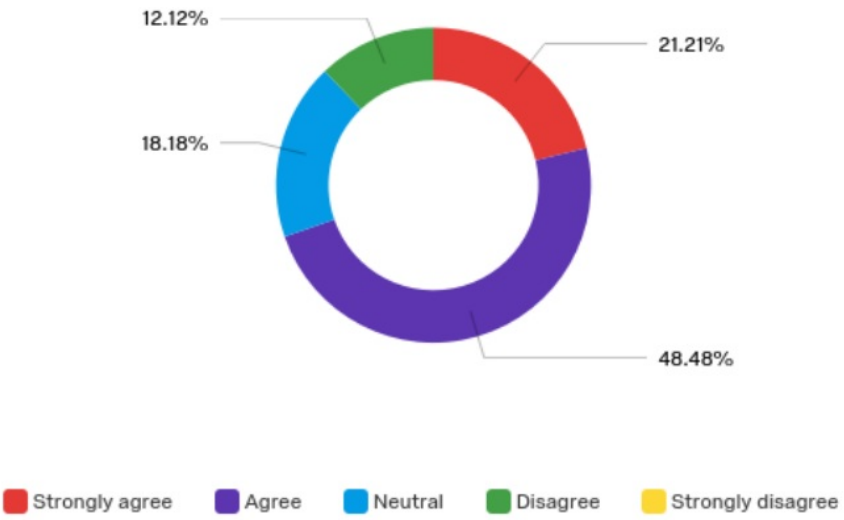
Q13 - Other people know where I stand oncontroversial issues



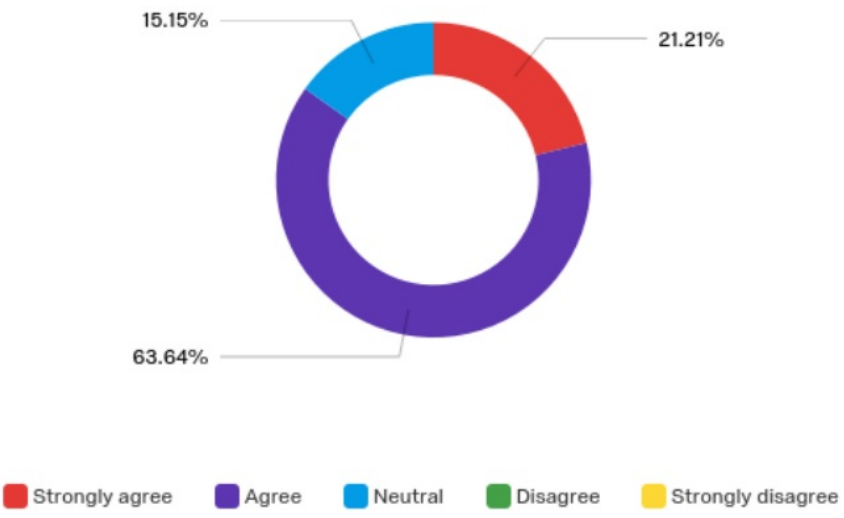
Q14 - I do not emphasize my own point of view at the expense of others



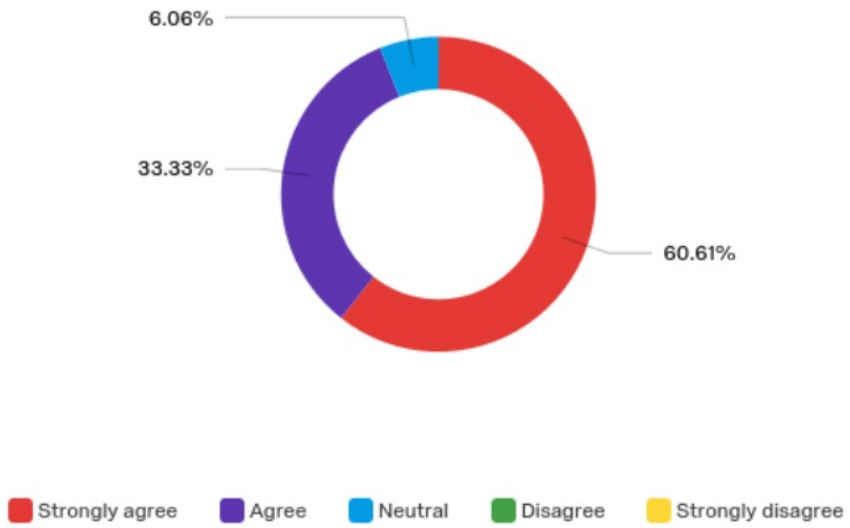
Q15 - I rarely present a “false” front to others



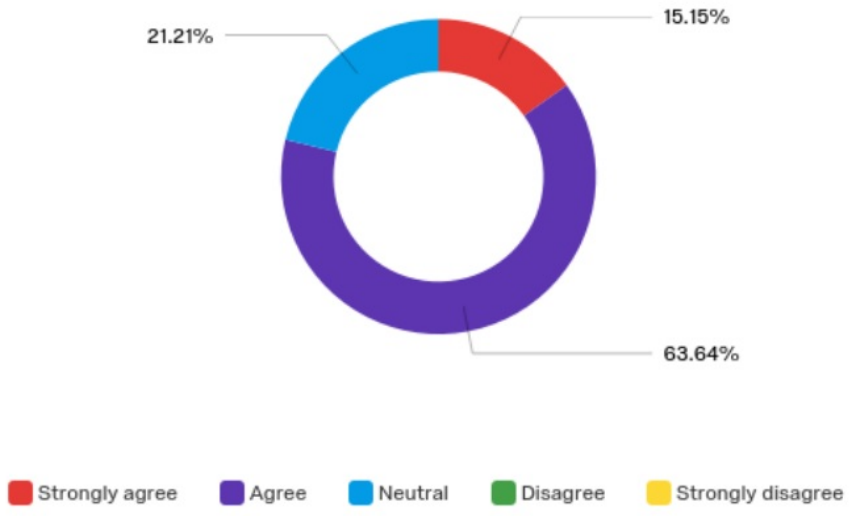
Q16 - I accept the feelings I have about myself



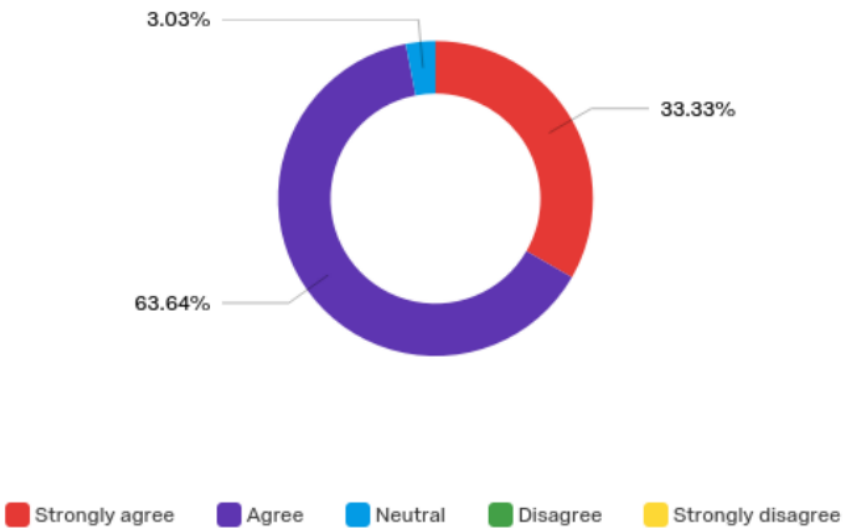
Q17 - My morals guide what I do as a leader



Q18 - I listen very carefully to the ideas of others before making decisions



Q19 - I admit my mistakes to others



Appendix C- Qualitative Interviews in full

Interview questions for persons in recovery from substances for two or more years and played an authentic leadership role in reducing opioid use in NH between 2015-2019.

1. **At what point did you realize you needed to take on a leadership role that involved publicly announcing your recovery status in service of efforts to reduce opioid use, overdoses, and/or related death?**

DL- I saw *The Anonymous People* when it came out in 2015, and I think that was the catalyst for me jumping into the fray as a person in recovery, whatever that was going to look like. Actually, I saw the trailer for the film and the invitation to host a showing in my community. So maybe the trailer was all the permission and inspiration I needed to start broadcasting my recovery status and working to raise public awareness that recovery from opioid injection use is possible. My next project was a fundraiser I decided to do for the rehab I went to, an effort to thank them for taking me in without any money. I told my local paper when and where the bowling event was going to be, and they wanted to interview me about my own recovery. I was still worried about how others in my 12-step recovery circles would react to me allowing my name and recovery status to be printed, even if I was confident, I wouldn't be breaking any rules if I did so. I gave the reporter a pseudonym – August McLoed or something. About a year later, I was telling my recovery story in that rehab, and a guy who had just been admitted recognized my story and said it was the reason he decided to go to treatment. I've had a lot of little moments like that egging me on to keep 'recovering aloud' and trying to build what I see is missing.

JH- 2015 I was publicly telling people such as State Reps about my recovery, talked about my recovery as a co-sponsor for naloxone bill, one of the few on naloxone commission. There was a

joint task force that I wanted to be part of; I let them know I was a triple threat: a doctor, in recovery and a legislator. Prior Authorization legislation but said it to the entire general court. Used his own story related to people having to wait 72 hours to get treatment, after I gave my speech, people who did not really like me came and hugged me after. If I had to wait 72 hours, I would have been dead. The committee in the House changed their votes based on your personal story, and this was an example of *authentic leadership. He was able to speak for naloxone to the entire house and had the floor. Joe was getting hugs from people who previously hated him because of his stance as a Republican. New Futures gave me an award in 2017 and Governor put him on a Marijuana De-Regulation, Joe was the only public person not holding a title that Gov. Sununu placed him on that committee.

2. **As a person in recovery or ally, did you feel like it was your purpose to work on building recovery capital when the opioid crisis started to develop in NH? If yes, what do you think is the most important milestone that you were involved in achieving?**

DL-As a person in recovery, I felt a little too lucky for having accessed treatment and for the experiences I have had along my recovery journey. I stopped using just before fentanyl started replacing heroin in NH. I was successful with the prevalent and prescribed 12-step treatment and recovery model. I was able to transition back into society from the safety of a halfway home. People took a chance on me and gave me roles and jobs that I was not qualified for. It has been all open doors since I got the help, I needed to stop feeling suicidal and chaotically to use drugs. I also feel a little too lucky for some of the experiences I did not have during my addiction, like going to jail or prison, being barred from housing or jobs because of a felony I somehow did not catch, contracting a serious disease, etc. Since Day One in my recovery, I've been watching

many equally deserving people have doors closed on them, and many of them die, cycle between jail and probation, or just struggle to find the stability that I've enjoyed as a model of privilege in recovery. So yes, guilt and general concern and a pre-existing social justice bent solidified my sense of purpose in recovery as centering around creating more inroads to stability for those with less privilege. I think the milestone that I was involved in, that I'm most proud of, was the launch of the first sustaining, above-ground syringe services program in NH. I think that some people in recovery and working in recovery services needed something and someone local to help them over the fence from 'Sure, I theoretically support variety in recovery experience' to 'Yes, I believe that harm reduction is a valid and essential avenue of recovery'. There's still a lot of work to do in that space, and in my mind that's among the most important paradigm shifts required to lessen these crises of overdose and crappy, discriminatory care.

JH: Board of medicine, testifying with my wife and a pharmacy because it needed to be well thought out instead of punitively passing laws that would affect patients, by putting tight hold on all opiates. Built recovery capital. Able to testify, "Said Hi, I am Joe and I am a Recovering Legislator." Most legislators in the room did not get the joke, as it is mimicked after an AA meeting.

Naloxone bill and Good Samaritan Bill, given a voice of recovery the guy well dressed, showed up in a suit. Syringe bill.

Leadership style helping people to get a role, getting people to know that they don't know; they have power to do things, making people feel like they need to be part of the solution. They do have an effect going on meaning they may be part of the problem, but you get to them and usually make a positive effect when you start with the solution.

Everything I do, I do expect it to have someone take it over from me.

I was talking with John Burns about a year ago (director of SOS Recovery Community Organization) about a staffing issue he was having. Essential people were moving on to more lucrative roles after staying at SOS and getting their credential. John was promoting people, and they had like 20 recoverees, and so then he needed to scramble to find recovery coaches to take the 20 recoverees all due to a promotion of one individual. Leadership style is to do the best I can.

Leadership is about having others stake the lead when you aren't there; I do nothing expecting to be there forever. Not married to any of my projects. There is an emotional attachment to some. Servant Leadership- the difference between management and leadership (researcher pauses to agree), management is telling you what to do; leaders show people how it's done.

Milestones-passing syringe exchange legislation. They are legalizing syringe service in NH. That changed the conversation on harm reduction instead of just don't do drugs. Real Leadership is about having others stake the lead when you aren't there, I do nothing expecting to be there forever. Not married to any of my projects. There is an emotional attachment to some. Servant Leadership- the difference between management and leadership(researcher pauses to agree), management is telling you what to do; leaders show people how it's done.

3. **How did you practice self-care when your day's work was related to overdoses and death of community members?**

DL-I can't say that I've maintained any sort of intentional self-care routine. I think in part, the traumas that influence my addiction serve to protect me against burnout or spiraling grief. I learned to detach from pain and today, that means I generally don't process painful news or experience in real time, if at all. This is an attribute that I've noticed makes certain people 'great

in a crisis.' But being detached has also kept me from developing big pieces of my recovery that have so far been missing: Feeling joy and developing deep, reciprocal relationships. Most of my negative feelings are pretty self-centered. They have to do with self-doubt, stress, and impostor syndrome. I manage those feelings by talking them out with peers and mentors, dissociating and procrastinating, and then just doing whatever work I need to do. Did/do you feel that your personal recovery or wellness is separate from the work that you did/do in helping others to initiate and sustain their recovery? If so, how did/do you maintain this separation? If not, please explain your own approach to wellness in your work.

The things I do for my recovery have changed so much over time, from heavily structured to totally unstructured. At first, helping people in recovery was certainly part of my recovery. I took roles working directly with people in recovery and then building services for them, and I think I was able to separate what I needed, and how I was doing, from what others needed, and how others were faring. I have found that something that I absolutely need in order to have stasis in my life, whether or not I take it too far, is a sense of purpose. So, I can't just self-care my way into wellness. That was apparent during week two in treatment when I found I had something to offer a new guy who was struggling, and that my helping him literally kept me in treatment. But I also have a lot of things to balance that don't involve 'the work' per se, such as my relationships with my wife and two daughters. Those other roles and responsibilities are also big pieces of my recovery. And how well I'm doing at balancing all of these roles are how I measure my recovery today.

JH- Having a healthcare background has allowed me to detach. We were trained for that. Even if I can't fix the problem, I still did something. If one person says thanks (at SOS) or you see one success story, you should really revel in that. Be proud and happy for the other person. For

everyone you hear about (died, OD, slipped) there are a bunch you do not hear about. There is a ripple effect; every little thing you do leads to a change. You made a change or took a step, simply saying hello to a homeless person, or reach out to someone who is suicidal, most ignore, how are you doing, its humanizing, littlest of change. Gandhi said, and I am going not to get this totally right, but Much of what you do is probably insignificant but its most important that you do it. Everything you are meant to do is not always monumental. We are human beings. More important to do the little things not just work on the big projects. Those big projects do not come along every day. Little things have a ripple effect. Interviewer notes last 15 months she's had lots of pebbles that were skimming across the water, to get to the bigger idea or project.

Self-care- I take really good care of myself. I go to bed with no worry.

4. **How did you go about developing your own personal mission to demonstrate a positive impact during the opioid crisis?**

DL-If I have a mission, I suppose it is to improve opportunities for and care of people who are beset by addiction. My understanding of how best to carry that mission out has changed significantly over my 6 years doing 'recovery work.' I think that's appropriate. I think the people who are effective in this recovery leadership space have lots of different missions – they are complicated people. But the missions that drive their best work are uncomplicated, unchanging, and developed unconsciously. 'Help people' isn't something you have to think about, and you can't will yourself to feel it more strongly than you do. I think someone who is a real leader in this space, with an overall mission of 'help people,' might negotiate with other missions like 'make money' and 'keep the peace' but doesn't let other missions crowd the main one. I've been told that even though I wrestle with other missions and priorities, people still trust that I'm loyal

to the 'help people' one. I'm not sure what that means about authentic leadership. But I'll say that I've never met someone that I identified as an authentic leader that ever did anything to change my mind about whether or not they embodied authentic leadership.

JH-You try to keep personal life separate, but everything you learn or do has an effect on others. My recovery has an effect I learn as much from someone with 30 days, and they don't think that they have anything to give. They don't realize they are helping you, must listen to everyone.

Syringe exchange and someone dies, someone, I am sure has overdosed and used our syringes, I don't know. Like, have a car dealer be responsible for an accident its customer happens. When someone overdoses and a kid died recently, Trevor, you've seen him. I asked myself could I do more. Saw Trevor 6-7 months ago, political event, Trevor was outside, do you know where the cafeteria. Why not come in and get the pizza. Invited him to get the pizza, 3-4 people from the event, Trevor was never offered a piece of pizza, was homeless, dirty, shopping bags, the supporters of the event were so embarrassed. Talked with him in the parking lot, started coming back around, but he died. Even if 99 die, saving 1 is important. If we don't do anything, then how can we impact doing something? Jesus would leave the 99 to save the one. Don't say you let 99 people die, say , I saved one. Learn from that tragedy, can't last in this business. The turnover is really high in this field. You have to be able to compartmentalize it and rationalize it. It's a personality trait.

5. **How did you go about developing your own personal mission to demonstrate a positive impact during the opioid crisis?**

DL-If I have a mission, I suppose it is to improve opportunities for and care of people who are beset by addiction. My understanding of how best to carry that mission out has changed

significantly over my 6 years doing 'recovery work.' I think that's appropriate. I think the people who are effective in this recovery leadership space have lots of different missions – they are complicated people. But the missions that drive their best work are uncomplicated, unchanging, and developed unconsciously. 'Help people' isn't something you have to think about, and you can't will yourself to feel it more strongly than you do. I think someone who is a real leader in this space, with a general mission of 'help people', might negotiate with other missions like 'make money' and 'keep the peace' but doesn't let other missions crowd the main one. I've been told that even though I wrestle with other missions and priorities, people still trust that I'm loyal to the 'help people' one. I'm not sure what that means about authentic leadership. But I'll say that I've never met someone that I identified as an authentic leader that ever did anything to change my mind about whether or not they embodied authentic leadership.

JH – Like help the 1 out of the 99. so many people did not have a voice. Able to focus that happened by default. It's all related. Social or political change is people based. Give voice, recovery happens, good example, at a new fellowship in NH. Reference to how proud the founder of Heroin Anonymous in the meeting had like less than a year of sobriety, and I am in a suit, in office at the time. Still using or less than a couple of weeks, people from that room are in recovery and working in field. I got recovery at 19. I was asked to speak, and I did not have heroin in my story. A 19-year-old came up to me after the meeting, no one told me that I did not have to go back to using. Three weeks, it still stuck with me. Not just doing what I have done, and there are levels of recovery. My mind was changed when I embraced harm reduction. I was invited to hemp fest; organizer was in recovery for Hemp Fest. Had friend in long term recovery, texted me one day how do I get a medical marijuana, chronic opiates or marijuana. His cancer is in remission, doing great not doing heroin again. Not my gold standard to have people

go from a 12 pack a day to 9, some of the things I have mentioned here are not my greatest achievements, but they took leadership in each example we discussed. Some of the best things were the little things so insignificant but most impact. Make you feel good

Leadership-big topic, so many things, best leaders are not managers; they are motivators, help build people up, on 2 boards SOS, Hope on Haven Hill, Statewide NH Harm Reduction Coalition and its policy director. Hands Ups Board too. VP Of Veterans of NH. Are you running again? I may, but I have a year to decide (Joe was the State Legislator for Barrington and Lee). It does offer benefits to bring things to the floor of the statehouse, but honestly, I can get more done without it.