Is the California Recovery Pathway of Benefit or Bane?

*"I am perfectly cured of the whisky habit, thanks to you and erthoxylon coca, but I can scarcely keep from forming a coca habit, becoming a "coquero"" – An 1889 l*etter from a patient to Dr W.H. Bently, Slaying the Dragon, the History of Addiction Treatment and Recovery in America - William White. Pg 146

We live in times in which it is increasingly difficult to sift through the evidence to distinguish helpful interventions that support recovery from those that result in harm. I recently read a recent study by Kelly et al (20265), Long-term relapse: markers, mechanisms, and implications for disease management in alcohol use disorder. It is an incredibly useful study for understanding how to improve long-term recovery rates. This journal article is about alcohol use disorders, yet it is reasonable to assume that it is also true for recovery from other substances as well. Research has shown that there are more similarities than differences between alcohol recovery and other substance recovery.

The evidence in Kelly et al 2026 suggests that recreational drug use (i.e., use of other non-alcohol substances) is one of the factors that can contribute to the resumption of use. The ways that this may occur includes reduced recovery vigilance, interfering with neurological recovery, disrupted mood and emotion regulation, increased social isolation as well as "kindle craving." This conclusion should make us wonder what harms may be unfolding in respect to "California Recovery" and how to address these harms. As the introductory quote above reminds us, we have a long history of things that present as solutions that end up causing great harm not readily apparent at the outset.

In a related interview on that paper above, when Dr John Kelly the principal researcher and Harvard University psychiatry professor was asked if there was there anything that he found that was particularly surprising. He described several findings, including recreational drug use among persons attempting recovery from alcohol addiction. He also highlighted how "recreational drug use, especially with this kind of California sober idea, when if you have a certain type of drug use disorder, like alcohol use disorder, then you use something like cannabis as a kind of a harm-reduction or coping tool. But a lot of these people using something like cannabis relapsed on their primary drug, which was alcohol." This is reflective of harm or bane, under the thin guise of benefit.

The definition of "California sober" is relatively simple – using weed but no other drugs or alcohol as recovery. The science of addiction recovery suggests several reasons why it may not work, including cross-substance cueing and neurobiological reactivation, which occurs because many drugs use share circuitry within the brain. Another factor may involve kindling. In simple terms, the kindling effect means that after repeated cycles of substance use, the brain becomes increasingly sensitive, so smaller triggers can lead to stronger cravings and faster relapses. In simple terms, each episode of use "primes" the brain, making it easier to fall back into addiction even after long periods of abstinence. Kindling can occur for persons with a severe alcohol dependency with the use of other drugs beyond alcohol.

For the above reason, Cannabis use would seem to create more harm than benefit. In fact, the Kelly et al study finds that recreational drug use is among the factors that increase risk of relapse from long-term recovery. Being a risk factor for relapse is the opposite of what "California sober" promises. "California sober" is best understood not as a harmless recovery pathway, but as a potential destabilizing factor within a broader relapse risk system, especially when measured over the long term. These matters are of life and death consequences to many of us in recovery and of bane, not benefit.

There is a very important 2024 longitudinal study (Subbaraman et al) sober living house residents that provides the most directly relevant, real-world evidence on what is now unfolding. This study took place in Los Angeles and followed approximately 550 sober living house residents for 12 months. Its primary finding is that residents who self-reported

using cannabis were actually more likely to have non-cannabis drug use days and higher rates of substance-related problems than those who use abstinence focused pathways. The researchers found that the use of cannabis is prevalent in the recovery houses examined, with roughly 1/5 of study participants increased their alcohol and other drug use. Those who were not using cannabis had lower odd of relapse and longer sustained recoveries. The authors suggest that the safest policy might be to prohibit cannabis use altogether in recovery housing.

Findings from other studies might be read to support "California sober." One such study found a short-term benefit to using cannabis to ameliorate withdraw discomfort and related facets of recovery initiation. The study, 'California sober'? Cannabis may help limit alcohol consumption, (Facher 2025) shows decreased use of alcohol among drinkers in comparison to placebo. It was a very different design and essentially found episodic benefit. Heavy alcohol users who also used cannabis tended to drink less alcohol per incident when they also used cannabis as they were able to reach the desired level of impairment with lower rates of alcohol use on the occasions measured. It did not consider longer term risks associated with these polysubstance use patterns. The study did not find that cannabis used in this way results in sustained remission. The study did not address long-term recovery stability and should not be generalized to people with more severe substance use condition histories.

Dr Kelly, who was not involved in the research, called the paper a "rare, well-controlled study," but cautioned that the promising short-term results are unlikely to translate to a long-term public health victory. Among people who attempt to substitute marijuana for alcohol, he said, "three scenarios typically occur: Their use of cannabis becomes a harmful addiction in and of itself; they find cannabis unsatisfying and return to alcohol; or they resume using alcohol but continue heavy marijuana use, making their behavior more harmful than before the attempted switch."

The idea of "California sober" is culturally and politically popular, but scientifically it is not currently supported as a reliable pathway to sustained remission. Quite to the contrary, in the real-world settings of recovery housing, it was found to increase relapse risk among Californians in long term recovery. Our systems push evidence-based processes yet the evidence for supporting "California Recovery" as a pathway to long term recovery from a severe substance use condition is simply not there.

We have groups like the Chicago Recovery Alliance (CRA) who consider recovery as "any positive change" as determined by the individual themselves. This definition would seem to include reduction in use or other harm reducing measures like using clean needles. In this way and with this definition, using cannabis is defined as recovery if it is a positive shift from a more harmful drug use pattern. Viewed in one way, such broad definitions of recovery seem like inclusive and positive steps, but we should ask ourselves do such extensively broad definitions really lead to less harm of people with severe substance use conditions? In respect to California Recovery, the available evidence does not suggest that it is the case if we consider the harm of relapses to other drug use and the resultant consequences.

The Great American Green Rush of Cannabis as Our Modern "Cure All" Elixir

Like the California Gold Rush that occurred in America in the 1850s in which a mad rush of 49ers migrated to the eureka state and found hardship, not riches, we are in the phase of the Green Rush in which the bloom is coming off the rose. Cannabis is simply not the magic elixir for all ills, including for addiction as was broadly claimed just a few short years ago. There was a rush then to open every door to the use of cannabis, including as an evidence-based addiction treatment.

My state of Pennsylvania is one of four states that have approved cannabis as a medication for opioid use disorder, with the other three being New Jersey, New York and New Mexico. Yet more recently a 2022 systematic review of Cannabis for Opioid Use Disorder has authors "in agreement that there is no consensus that use of cannabis is associated with improved treatment outcomes in people with OUD." So now we have a powerful drug that is sold in various strains and potencies with ever more inventive ways to deliver the drug to the brain in more concentrated and fast processes codified into law as a benefit when for many of us it is a life-threatening bane.

There are also eight states that approve cannabis medically for the treatment of anxiety, New Jersey, New Mexico, New Hampshire, North Dakota, Oklahoma, Pennsylvania, Utah and Nevada. These approvals exist despite growing evidence reflecting that it is not an effective treatment for anxiety and fairly conclusive evidence that THC increases anxiety in higher doses. Medical Cannabis for anxiety is also dispensed in ways that make the potency and dosing nearly impossible to determine. A 2026 paper in the Lancet (Wilson, et al) did a meta-analysis of 54 randomized controlled trials (n=2,477)

and found *no significant evidence* that cannabinoids improve anxiety disorders. It did not find clinically meaningful benefit across the trials examined but did find that adverse effects were common.

In states with medical cannabis, licensed drug and alcohol treatment providers can be required to accommodate harmful cannabis in their addiction treatment centers, including for anxiety and as a treatment for Opioid Use disorders. The research shows that this can be detrimental to the care of the people they are charged to treat. Hopefully we will revisit these policies in the near term as our evidence base develops. One wonders what influence the cannabis industry has had here in spurring on the great green rush of Cannabis sales. A 2020 study suggests that that these pro drug use policies might promote unsupported claims by the cannabis industry about cannabis' benefits for medical benefit, including for anxiety and OUD treatment.

For many of us with severe substance use disorders, drug use is a life-threatening prospect. It is easily understood why the authors of the LA study on California Recovery suggest that the safest policy might be to prohibit cannabis use altogether in recovery housing. Is any governmental or watchdog group tracking potential harms of benefits to the residents of these programs? The bigger question is how many lawmakers and regulators across the nation will stand in the crosshairs of this 30 Billion dollar a year and growing industry?

For readers, I would ask, what would you want in respect to safe recovery housing for your loved one? For lawmakers and regulators, I ask on which side of the ledger of history do you want your name listed?

Questions to consider:

- Do we consider all pathways of recovery equal even if some have been found to sustain addictive drug use?
- How do we address the narrative of the cannabis advocacy movement and the industries of addiction to separate benefit from bane?
- Do we have an ethical obligation to do no harm? How does that relate to cannabis use as medicine for persons with severe substance use disorders?
- How does active drug use in spaces like recovery housing create a safety risk for people for whom drug use is a deadly proposition? When does personal right become a communal risk?
- Who is objectively considering cannabis policy in respect to addiction treatment and recovery support?

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