White, W. (2002). The treatment renewal movement. *Counselor, 3*(1), 59-61.

The Treatment Renewal Movement

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Two emerging movements, a new grassroots recovery advocacy movement and a treatment renewal movement will, through their success or failure, reshape the character of addiction treatment and recovery in America in the early twenty-first century. This second article of a two-part series describes the latter of these movements.

The Context for Renewal

There are several forces from outside the field of addiction treatment that are challenging the field's cultural ownership of alcohol and other drug problems. The restigmatization, demedicalization and recriminalization of these problems in the 1980s and 1990s undermined the perceived legitimacy of addiction treatment as a cultural institution and moved a growing number of people with alcohol and other drug problems from systems of professional care to systems of punishment and control. During this same period, a loosely organized backlash movement challenged the conceptual foundations of modern addiction treatment. This movement's core texts, celebrity speakers and internet web sites argued that:

- Alcoholism/addiction is a myth–that no such self-contained clinical entity exists (Davies, 1992, 1997).
- Excessive alcohol and other drug use is not a disease; it is a choice (Fingarette, 1989; Schaler, 2000).
- Addiction treatment and the mutual aid institution (Alcoholics Anonymous) upon which it is primarily based are ineffective and potentially harmful (Peele, 1989; Peele, Bufé, and Brodsky, 2000).
- Public funds should not be used to support addiction treatment (Trimpey, 1996).

The field of addiction treatment also faced technical and ethical challenges in the 1980s and 1990s that tarnished its image and contributed to rising therapeutic pessimism about the prospects for permanent recovery from addiction. The technical deficiency involved using an acute model of intervention and then overselling the ability of a single, brief treatment episode to bring severe alcohol

and other drug problems into sustained remission. Subsequent serial episodes of acute treatment for large numbers of clients left communities concluding that 1) individuals who return to alcohol/drug use following treatment are failures and untreatable, 2) the local program is not a "good" program, or that 3) the condition itself is untreatable and should be managed in other ways. The public image of treatment institutions was also injured by exposés of exploitation within such arenas as marketing, fee-setting/collection, and financially-motivated admission, discharge, re-admission, and length of stay decisions. These exposés portrayed treatment practitioners more as hustlers than healers. As the public perception of the value of addiction treatment changed, the treatment field was forced to take a serious look at itself.

II. State of the Field

Most professional fields and the organizations that make up such fields go through cycles of renewal and decline. Periodically replenishing a field from within is as essential as renewing its relationship with the culture and communities within which it is nested. There were a number of critical signs in the 1990s suggesting the need for such a renewal process in the field of addiction treatment.

Decay was evident in the declining membership of key organizations. The number of affiliates of the National Council on Alcohol and Drug Dependence declined from a peak of more than 240 in the early 1980s to less than 90 by the late 1990s. Membership in the National Association of Addiction Treatment Providers fell from its peak of 800 in the late 1980s to 96 in 1996, before beginning to rise again to its current membership of 182. NAATP membership attrition reflected the dramatic decline in hospital-based and private treatment programs in the 1990s. Similarly, membership in NAADAC declined from 17,204 in 1994 to 13,162 in 2000. All of these declining numbers were accompanied by something of an identity crisis as many addiction treatment programs (and their funding authorities) were merged within larger mental health or public health entities. By 2000, the field was growing at its periphery (e.g., into the criminal justice and child welfare systems) at the same time its historical core appeared to be shrinking. Old-timers began to lament the potential death of the field by diffusion and absorption–a loss of the field's core values and service technologies amidst the illusion of the field's continued existence.

Another sign of concern at the close of the century was the pattern of tenure and turnover in the field. Senior administrative and clinical positions in many agencies were filled by persons who had long served in these roles, while surveys

revealed a 30-40% annual turnover rate for front line service positions. The field now faces significant morale problems among its front line practitioners at the same time its elders are set to exit the field in mass in the next decade taking much of the oral history and experience from this modern era with them. When long time addiction counselors are asked to critique the state of the field, they often depict a field whose institutions have lost touch with their historical roots and founding missions and who have become isolated from the very communities out of which they were born. Many depict institutions more preoccupied with financial self-maintenance than clinical outcomes–seemingly more concerned with the presence of a progress note than the progress of a client. Others contend that addiction treatment has become detached from the larger and more enduring process of recovery and divorced from the major findings of addiction science. Collectively, they suggest that it is time the field conducted a searching and fearless self-inventory and got itself ethically and clinically re-centered.

The Treatment Renewal Movement

The signs of a treatment renewal movement can be seen across the country. It can be seen in professional meetings of addiction counselors where one hears repeated calls for a new wave of activism aimed at getting the field refocused on the long term recovery of clients and families. It can be seen in the reflections of the field's long-tenured leaders who at the sunset of their careers are seeking to solidify their legacies. It can be seen in the coalitions with other agencies and indigenous institutions that are forging new models of serving multiple problem clients and families. It can be seen in the growing dialogue between researchers and front line counselors. It can be seen in the way that treatment agencies are working with new recovery advocacy organizations to enhance local community recovery resources. The three emerging goals of this treatment renewal movement are to:

- Refocus and refine the historical missions, core values and ethical standards of professional practice of addiction treatment agencies,
- Forge a meaningful integration of two ways of "knowing": the knowledge of science and the knowledge of cumulative clinical and recovery experience, and
- Rebuild the relationship between addiction treatment agencies and the communities and constituencies that they serve.

Keeping Our Eyes on the Prize An increasing number of treatment agencies are holding agency retreats to self-assess themselves as organizations and to get themselves reconnected with their past and repositioned for the future. Flowing from these meetings are re-commitments to service, refined mission and vision statements and new or updated codes of professional practice. These same processes are evident as agency leaders come together within their state, regional and national organizations. It is in these latter sessions that one finds broader discussions about extending this refocusing effort into the arena of policy advocacy. Also evident in such settings is a growing awareness of the coming leadership crisis and many emerging proposals for leadership development, leadership succession and increased staff support. This element of the renewal movement is strengthening the organizational infrastructures and service cultures of addiction treatment agencies.

Clinical Research and Clinical Practice The significant federal investment in addiction research is now paying dividends. Such dividends span new discoveries about neurobiological roots of addiction through the development of new evidence-based treatments. The list of potential applications of this research is a long one but particularly striking are:

- the conceptualization of addiction as a "brain disease" and the elucidation of the mechanisms of this disease process;
- new breakthroughs in the understanding of the role of trauma as an initiating and sustaining force in addiction and potential barrier to treatment and recovery;
- new developmental models of recovery with stage-appropriate engagement and intervention techniques;
- new pharmacological adjuncts; and
- the refinement of addiction treatment protocol for particular clinical subpopulations.

Also of note is the potential mainstreaming of clinical trials technology emerging from such studies as Project MATCH and the Cannabis Youth Treatment Study. The goal of such mainstreaming is not just to move evidence-based therapies into the front lines of addiction treatment but to also transfer the clinical infrastructure within which treatments are tested within multi-site randomized clinical trials (Carroll, 1997). This clinical infrastructure is itself part of the emerging technology of addiction treatment and includes such elements as:

- Defining, proceduralizing and manualizing the active ingredients of a particular treatment approach,
- utilizing competency-based training to verify and certify clinician skills in executing the treatment,
- monitoring the continuing delivery of treatment via fidelity measurement instruments and procedures,
- individualizing treatment within the framework of clinical supervision, and
- applying principles of chronic disease management to the treatment of severe and persistent alcohol and other drug problems.

These research advances are propelling many agencies to shift from offering a "program" to offering "treatment and recovery support service menus" from which unique service ingredients, service combinations, and service sequences are being matched to the needs of particular clients/families.

Treatment, Recovery, Community

The board and staff of Dawn Farm (until recently a traditional therapeutic community in Ann Arbor, Michigan) invited a large number of stakeholders (funding agencies, current/former clients, allied agencies, mutual aid leaders, clergy, and local officials) to a community meeting. At the meeting, Jim Balmer, Dawn Farm's director, reviewed the organization's history and then acknowledged that Dawn Farm had evolved a variety of policies and procedures over the years that in their cumulative effect had made it harder for people to enter and successfully complete treatment. He concluded by offering an apology to the community and asking those present to enter into partnership with Dawn Farm to help the board and staff reshape Dawn Farm's relationship with, and responsiveness to, the local community. That renewed community partnership has led to a change in Dawn Farm's service philosophies and its involvement in such new ventures as street and jail outreach, sober housing and participation in multi-agency service models for clients with special needs. Dawn Farm is among a vanguard of addiction treatment programs who are redefining the relationship between treatment, recovery and community.

Understanding this power of the community to harm and heal is at the heart of efforts to move the locus of treatment and recovery from the hospital, residential program, or clinic into the natural settings in which AOD problems are initiated

and sustained. This approach does not deny the role of biological or psychological variables in the onset of AOD problems, but it does force us to recognize that the long term course of these problems are influenced by the relative strength and pervasiveness of local cultures of addiction and cultures of recovery (White, 1996). Both barriers to and incentives for recovery exist in the community space surrounding our clients and it is into that space that addiction treatment professionals are beginning to carry their service interventions.

Treatment organizations that redefined themselves as businesses in the 1980s are now recapturing their lost identities as community service agencies. They are recapturing such lost functions as community education, community resource development, community organization, and public policy advocacy. They are moving into the very heart of their communities and, like Dawn Farm, inviting greater community and recovery constituency participation within their organizations. Treatment agencies are rejoining their communities and rediscovering the natural healing powers that lie within these communities. When universities became too isolated from their local communities, there were calls for these institutions to move back into the life of their communities–to become "universities without walls." What is emerging in this treatment renewal movement is advocacy for an analogous process of treatment and recovery without walls.

A Window of Opportunity

Very few professionals have an opportunity during their lifetime to shape the ultimate destiny of their chosen fields. That opportunity is at hand for addiction professionals. Leadership vacuums are emerging that must be filled.

As a field, we have too often played the role of the chameleon, reflecting not character but context, constantly changing color with the latest funding demand or regulatory site visit. All too often we have let forces other than the needs of our consumers dictate who we treated; what, how and by whom treatment was provided; and when and how long treatment was provided. It is time the field broke the chains of its passivity and once again advocated, not for itself, but for the needs of those it is pledged to serve.

If there is anything addiction counselors know it is that there are brief developmental windows of opportunities that when capitalized upon can forever alter the trajectory of one's life. The same is true for cultures, communities, and professional fields. That window of opportunity exists today, but it is narrowing. The future of this field and the future of recovery in America will be shaped by our

silence or our voice. Speak out about our need to remain client-centered. Become a serious student of addiction research. Lead the movement back into our communities. Where you see evidence of this treatment renewal movement, support it. Where this movement lies dormant, help incite it. We must speak boldly and act with courage while that window of opportunity is still open.

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