

Recovery-oriented Practice and the Addictions Professional: A Systems Perspective

Recovery is the Very Soul of Our Profession

WILLIAM L. WHITE, MA AND CYNTHIA MORENO TUOHY, NCAC II, CCDC III, SAP

Modern addiction treatment as a system of care emerged in the early 1970s. This birthing process was followed by sustained and turbulent processes of professionalization, commercialization and bureaucratization. New specialized addiction treatment programs were a godsend for people with alcohol and other drug problems and their families who in earlier years faced few if any resources, contempt from mainstream helping professionals, and all too often, harmful interventions masked as help. Today, hundreds of thousands of people in long-term recovery owe their lives to modern addiction treatment. So why in the past decade have we witnessed repeated calls from people in recovery and from long-tenured addiction professionals for greater recovery orientation in addiction treatment? Aren't addiction treatment and addiction counseling already recovery-oriented? In this brief essay, we will offer some historical perspectives and systems performance data to answer these questions.

Lost Connection to Recovery

There are remarkable milestones in the rise of a national infrastructure of addiction treatment, each worthy of a detailed recounting: discovery of replicable models of addiction treatment, expansion of public and private funding for addiction treatment, explosive growth of community-based treatment programs, development of program accreditation and counselor certification standards, birth of professional associations and addiction studies programs, and increased rigor addiction research, to name just a few. Yet, by the mid-1990s, as addiction treatment episodes became ever-briefer, there were warning voices suggesting that something important was being lost in the professionalization and industrialization of addiction treatment. One could hear at national conferences and read in the field's professional journals fears that addiction treatment was becoming disconnected from the larger and more enduring process of addiction recovery and that recovery initiation in institutional settings was disconnected from processes of recovery maintenance within natural community environments (Elise, 1999; Morgan, 1994; White, 2004). A growing recovery advocacy movement also challenged that an addiction treatment field that once viewed itself as an adjunct to recovery was now viewing recovery as an adjunct (afterthought) to itself (White, 2001).

Key System Performance Measure

The opening decade of the 21st century witnessed two additional shifts that exerted a profound influence on addiction treatment. The first was the refined conceptualization of addiction as a chronic condition (McLellan, Lewis, O'Brien, & Kleber, 2000) and discussions of the implications of such an understanding to clinical practices in addiction treatment (Dennis & Scott, 2007; White, Boyle, & Loveland, 2002). The second shift involved an intensified analysis of what addiction treatment was and was not achieving as a system of care. Critiques of key system performance measures (e.g., White, 2008a) concluded that there were major problems with addiction treatment in such key areas as 1) attraction and access (only 10% of those with a substance use disorder enter treatment each year), 2) engagement and retention (less than 50% successfully complete treatment), 3) clinical practices (significant gaps between clinical research and clinical practices), 4) linkages to communities of recovery (use of passive rather than assertive linkage procedures), 5) service duration (less than optimum 90 days across levels of care), 6) continuing care (only 20–36% of adolescents and adults receive post-treatment monitoring and support), 7) post-treatment substance use outcomes (more than 50% of persons leaving treatment resume substance use within year of discharge, with most occurring within 90 days of leaving treatment) and 8) treatment recycling (64% of persons entering addiction treatment have a prior treatment; 19% have five or more prior treatment episodes).

Recovery as an Organizing Paradigm

These processes of professional self-inventory and systems performance evaluation triggered calls to: 1) shift the field's organizing center to one focused on recovery rather than addiction pathology or clinical/social intervention, 2) extend the design of addiction treatment from one focused almost solely on acute biopsychosocial stabilization (recovery initiation) to one that encompassed support for long-term personal and family recovery (recovery maintenance and enhanced quality of life in recovery) and to 3) nest these models of sustained addiction recovery management (ARM) within larger recovery-oriented systems of care (ROSC; White, 2005, 2008a,b). The calls for this conceptual shift in the field were not without challenges.



From this... to this.

Some countered that the recovery concept was amorphous (“Is it like pornography? You can’t define it but you know it when you see it?”), redundant (“We’re already recovery oriented.”), faddish (“a flavor of the month”), impractical (“No one will fund long-term recovery support.”) and dangerous (“Recovery is a political Trojan horse aimed at de-professionalizing, delegitimizing, and defunding science-based treatment and harm reduction services.”). Such were the challenges that faced early ARM/ROSC pilot settings (e.g., the State of Connecticut and the City of Philadelphia) and recovery-focused policy shifts within the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment and the White House Office of National Drug Control Policy.

Defining Recovery and Recovery-oriented Practice

The emergence of recovery as a new (or renewed) organizing framework for addiction treatment and the larger alcohol and other drugs policy arena sparked efforts to reach a consensus definition of recovery (Betty Ford Institute Consensus Panel, 2007), develop recovery-oriented practice guidelines (Abrahams et al., 2012; Tondora et al., 2008) and forge a recovery-focused research agenda (Laudet, Flaherty, & Langer, 2009) that could collectively guide the future design of addiction treatment and peer recovery support services. These efforts, led by addiction professionals and people in recovery, point to a future of more person- and family-centered care and the increased involvement of addiction professionals in pre-treatment and post-(acute) treatment stages of addiction recovery. They also point to a future in which addiction professionals will be working in an ever-expanding variety of service settings and providing an expanded menu of clinical and non-clinical recovery support services. They portend a future in which addiction treatment and addiction recovery are inseparable and in which the physical, psychological, and social barriers separating the treatment institution from indigenous recovery supports in the community no longer exist (a move toward “treatment without walls”). That redesign process is already underway — pushed by recovery advocates, visionary professionals and the cumulative findings of scientific research.

A Time for Activism

NAADAC’s founding generation spent their lives widening the doorways of entry into addiction recovery. They fought to create a treatment system and a new profession (addiction counseling) to achieve that vision. The present call for increased recovery orientation within the field is in many ways a call to renew that founding vision. Many things diverted this recovery focus over the years. There were days when addiction counselors found themselves working in systems that seemed to care more about progress notes than the real progress of those being served. Yes, at times it seemed like the “new profession” would, in its worship of regulatory compliance, drown itself in a sea of paper. There were days when addiction counselors found themselves in systems that seemed more preoccupied with money management than recovery management. Yes, fixations on funding and profit have sometimes obscured the ultimate goal such resources were to serve. And yes, there were times preoccupations with our own professional status also served as a distraction from our founding recovery vision. But addiction counselors and NAADAC have always found ways to renew this vision and add our voices to those of our founders who challenged us to keep our eyes on the ultimate prize of this profession: the long-term recovery of individuals, families, and communities.

Addiction treatment as a cultural institution (as well as the role of the addictions professional) remains on probationary status within the United States and other countries of the world. The future of the

field is by no means assured. It is our contention that the fate of the field will rest upon the degree of optimism — or pessimism — in which addiction recovery is viewed by the larger culture. In a culture awash with media coverage of celebrities constantly recycling in and out of “rehab,” it is our voices that must help convey two messages: 1) long-term recovery is a reality in the lives of millions of individuals and families, and 2) professionally directed addiction treatment can be a critical adjunct in recovery initiation, recovery maintenance, and enhancement of quality of personal and family life in long-term recovery. Our charge is to now renew, and never again lose, this recovery vision. In the midst of all manner of health reform and service integration initiatives, that vision cannot be lost. Recovery is not a new innovation, nor is it a passing fad. It is the very soul of our profession.



William L. White is a Senior Research Consultant at Chestnut Health Systems/Lighthouse Institute and past-chair of the board of Recovery Communities United. White has a Master’s degree in Addiction Studies and has worked full time in the addictions field since 1969 as a street-worker, counselor, clinical director, researcher and well-traveled trainer and consultant. He has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 16 books. His book, *Slaying the Dragon — The History of Addiction Treatment and Recovery in America*, received the McGovern Family Foundation Award for the best book on addiction recovery. His collected papers are posted at www.williamwhitepapers.com.



Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, is the Executive Director of NAADAC, the Association for Addiction Professionals. She previously served as the Executive Director of Danya Institute and the Central East Addiction Technology Transfer Center and as Program Director for Volunteers of America Western Washington. In addition, she has over 20 years of experience serving as the administrator of multi-county, publicly funded alcohol/drug prevention/intervention/treatment centers with services ranging from prenatal care to serving the elderly.

References

- Abrahams, I. A., Ali, O., Davidson, L., Evans, A. C., King, J., Poplawski, P., & White, W. (2012). *Practice guidelines for recovery and resilience oriented treatment*. Philadelphia: Philadelphia Department of Behavioral Health.
- Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228. doi:10.1016/j.jsat.2007.06.001
- Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, 4(1), 45-55.
- Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery*, 6(2), 11-23.
- Laudet, A., Flaherty, M., & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695. doi:10.1001/jama.284.13.1689
- Morgan, O. J. (1994). Extended length of sobriety: The missing variable. *Alcoholism Treatment Quarterly*, 12(1), 59-71. doi:10.1300/J020v12n01_05
- Tondora, J., Heerema, R., Delphin, M., Andres-Hyman, R. O'Connell, M. J., & Davidson, L. (2008). *Practice guidelines for recovery-oriented care for mental health and substance use conditions* (2nd ed.). New Haven, CT: Yale University Program for Recovery and Community Health.
- White, W. L. (2001). The new recovery advocacy movement: A call to service. *Counselor*, 2(6), 64-67.
- White, W. L. (2004). Recovery: The next frontier. *Counselor*, 5(1), 18-21.
- White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 23(1), 3-15. doi:10.1300/J020v23n01_02
- White, W. L. (2008a). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.
- White, W. L. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse*, 43(12&13), 1987-2000. doi:10.1080/10826080802297518
- White, W. L., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, 20(3/4), 107-129. doi:10.1300/J020v20n03_06