

Why Recovery? Why now?

Opening Remarks at the 2012 UCLA / Betty Ford Institute First Annual Recovery Conference

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Introductory Note: On February 21-23, 2012, the Betty Ford Institute, in collaboration with UCLA, sponsored the fourth in a series of recovery-themed consensus conferences. Held at the Betty Ford Center in Rancho Mirage, CA, the conference was attended by federal policy leaders (ONDCP, NIAA, and NIDA), addiction research scientists, recovery advocates, and recovery support specialists. Below are my welcoming remarks to those attending.

I have been asked tonight to set the stage for our conference by offering a few remarks related to three questions: 1) Why recovery? 2) Why now? 3) Why this conference?

Ironically, this may be the one group of people in the world who could each provide a detailed response to these questions.

Why Recovery?

Historians place the rise of a specialized field of study and professional intervention into alcohol and drug problems between the late 18th and mid-19th centuries. In the time since, the alcohol and drug (AOD) problems arena has been dominated by two organizing frameworks: a pathology paradigm that assumed long-term solutions to these problems would be revealed through the study of the etiology, patterns, course, and personal and social outcomes of AOD problems, and an intervention paradigm that assumed solutions to AOD problems could be found in rigorously evaluating social and clinical interventions into these problems. These organizing frameworks have produced a voluminous quantity of scientific and clinical knowledge, but their limits have set the stage for a more solution-based framework focusing on the study of resilience, resistance, and recovery. I want to share a few thoughts about the importance of this new recovery frontier.

As a country, we have offices, institutes, and centers of “drug control,” “drug abuse,” “alcohol abuse and alcoholism,” and “substance abuse treatment” but no offices, institutes, or centers of recovery. As a field, we have journals of *addiction*, *addiction research and theory*, *addictive behaviors*, *addictive diseases*, *alcohol research*, *alcoholism*, *alcohol and drugs*, *drug and alcohol abuse*, *drug and alcohol dependence*, *drug and alcohol studies*, *psychoactive drugs*, *drug issues*, *drug problems*, *drug policy*, *substance abuse*, *ethnicity in substance abuse*, *substance use and misuse*, as well as journals of *alcoholism treatment*, *substance abuse treatment*, and *maintenance in the addictions*, but only one journal that even contains the word recovery in its title (*Journal of Groups in Addiction and Recovery*) and no journal specifically focused on the science of addiction recovery. We have addiction technology transfer centers, but no recovery technology transfer centers; addiction studies programs but no recovery studies programs; addiction medicine specialists and addiction professionals but until very recently, no recovery specialists.

As a result, the etiological pathways into AOD problems have been well-charted, but pathways and styles of long-term addiction recovery remain a rarely explored frontier. The national prevalence and patterns of AOD use and related problems are surveyed every year, but there are no comparable systematic surveys of the prevalence and patterns of recovery. More importantly, the professional and scientific community has failed to provide answers to some of most important questions faced by people in recovery. The normative stages and strategies of long-term personal and family recovery are not available to those who most need this information except “in the rooms” of mutual aid groups where the only scientists present are there to support their own recoveries.

The challenges and opportunities of living in recovery across the life cycle have not been mapped. The addiction pathologists tell those of us in recovery that our children are at increased risk of developing AOD problems, but they offer no information on whether or how our recovery status alters that risk, no information on parenting strategies that might alter their vulnerability or enhance their future early recovery prospects. People are entering recovery younger and younger, and yet little information exists about living a life in recovery that begins at age 15 or 25 rather than 45 or 55. There is a large cohort of people in long-term recovery facing late life challenges: loss of parents, siblings, spouses, children, sponsors, and friends; adult children returning home; impairing and life-threatening medical conditions; acute and chronic pain; proffered medication remedies; loss of work or retirement; financial distress; and other late life issues.

Some within this cohort experience a reoccurrence of addiction after years of stable recovery. As communities of people in long-term recovery turn to addiction scientists and clinicians in search of guidance on such issues, we find little recognition of our existence and little guidance. So we turn to each other and wonder collectively why after decades of research investment, our most basic questions about recovery remain unanswered.

What we know about alcohol and drugs, addiction, and the short-term treatment of addiction fills libraries, and this knowledge has helped many people start their recovery journey, but what we know as a professional field about long-term personal and family recovery from addiction from the standpoint of science and clinical practice could at best barely fill a few scant shelves within such libraries (and most of these would be unpublished dissertations).

In 2011, more than 100,000 individuals and families in recovery and their friends and allies marched in more than 200 U.S. recovery public celebration events during Recovery Month. Hundreds of thousands of people in recovery are today standing publicly, declaring their existence, and calling for recovery support resources and a recovery research agenda. They are suggesting that it is time we tapped the large well of lived recovery experience and used the lessons from such experience to build on what we have learned from the study of addiction pathology and brief addiction treatment.

Why Now?

As to the “Why Now?” question, there are several potential answers historically, but one stands out in prominence. For decades, we have been concerned about bridging the chasm between research and practice in addiction treatment with the implicit assumption that research knowledge was far ahead of clinical practice. In the recovery arena, in marked contrast, we need a practice to research initiative. Put simply, practice is far ahead of the research. The growth and diversification of recovery mutual aid; the recovery advocacy movement; new recovery support institutions; the emergence of recovery as a new federal, state, and local organizing paradigm; widespread experiments with recovery management (RM) and recovery-oriented systems of care (ROSC) sparked by the pioneering work in Connecticut and Philadelphia; and new service roles, particularly the role of recovery coach, are transforming the recovery landscape in the United States and beyond in ways that are profoundly affecting and will affect the future of addiction treatment and recovery. Policy-makers, research

scientists, and addiction professionals, who are not oblivious of this fact, are running to catch up. I would suggest that the window of time for them to serve this broader movement or to create the illusion that they are leading it is a narrow one.

Why a Meeting of This Kind?

As to why there is a need for an annual recovery conference, the answer is quite clear. At present, thousands of recovery-focused initiatives are underway across the U.S., but there is no structure for connecting the dots to understand the picture of what is unfolding or to evaluate the impact of these projects at either a local or global level. We need to regularly gather key people from diverse stakeholder groups to evaluate what is emerging in this shift towards a recovery paradigm and to create a forum for consensus and advocacy statements. Such a forum will help facilitate alignment of research, policy, and service practice to support long-term recovery; enhance quality of personal and family life in long-term recovery; break intergenerational cycles of problem transmission; and create a larger healing force within American communities wounded by AOD and related problems. The exemplary contributions and unique perspectives of those assembled for this meeting offer us a unique opportunity to achieve this vision. I wish each of us Godspeed on our journey into this new recovery frontier.