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Recovery: The Next Frontier

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The history of the addictions field has been one of evolving paradigms (organizing constructs), evolving core technologies and evolving definitions of the field's niche in the larger culture whose needs it must serve. This article traces the evolution of the field's organizing paradigms through three overlapping stages, a problem-focused stage, an intervention-focused stage and an emerging solution-focused stage. These paradigms can be viewed as competing models but are best viewed as developmental stages, with each preparing the emergence of the next.

The Pathology Paradigm

The first stage was launched by what Levine has (1978) christened "the discovery of addiction." This birthing stage in the late eighteenth century was sparked by a break from prevailing moral and religious frameworks of understanding and responding to chronic drunkenness. Compulsive and destructive AOD use became defined as a disease of the body and the will, a redefinition that has sustained more than 200 years of research on the

nature of psychoactive drugs, their acute and chronic effects, the multiple sources of individual vulnerability to AOD problems, and the stages of AOD problem development. An enormous body of literature exists and continues to be generated on the psychopharmacology and epidemiology of AOD problems. Elaborate systems of data collection exist to measure the slightest shifts in drug-related attitudes, beliefs, and behaviors. A research industry exists whose sole mission is studying drugs, their patterns of consumption, and their personal and social costs. As a culture and a professional field, our knowledge of psychoactive drugs and drug addiction is impressive. This cultural investment in studying the nature of AOD problems reflects a pathology paradigm—the assumption that knowledge of the sources of a problem will lead to its eventual solution. Knowledge gained within this paradigm provided significant benefits and laid the foundation for policy, educational and clinical responses to AOD problems.

The Intervention Paradigm

Attempts to personally and socially resolve AOD problems also have a long history in America. These attempts span AOD-related social policies, education and prevention efforts, early intervention programs and addiction treatment. A voluminous body of knowledge and resources (including this journal) exists that focus on when and how to intervene in these problems. The readers of this journal have been part of this country's unprecedented investment in the professionally-directed treatment of AOD problems. Some readers are old enough to have witnessed the transition of treatment from an unfunded folk art to a highly professionalized and commercialized industry. We have learned within this modern era of treatment how to interrupt addiction careers. We know a lot about engagement, detoxification, problem stabilization, and recovery initiation. We know a lot about what people look like in the years before they were admitted to treatment. We know a lot about what people look like during treatment. And we know a little bit about what people look like in the months following treatment.

The knowledge gained from this intervention paradigm has advanced the field and allowed hundreds of thousands of individuals to initiate and sustain recovery. The majority of drug dependent persons who achieve sustained recovery do so after participating in treatment (the percentage varies by substance: cannabis (43%), cocaine (61%), alcohol (81%) and heroin (92%) (Cunningham et al., 1999, 2000). That knowledge has also illuminated the limitations of our current treatment system. For persons with severe AOD problems, it often takes three to four episodes of acute treatment over a span of eight years to achieve stable and enduring recovery (Dennis, Scott, Funk & Foss, under review). These findings challenge models of brief treatment, short-term aftercare, and follow-up studies whose designs, until recently, extended only several months following discharge from treatment. These shortcomings have led to calls for more

recovery-sustaining models of intervention and support and more recovery-focused research and evaluations activities. In short, there is growing interest in extending the pathology and intervention paradigms into a more fully developed recovery paradigm.

Agitation for Change

For readers who think they and their program and the larger field are already recovery-focused, it may be helpful to view this issue through the eyes of the recovery advocates (of the 1950s-1960s) who were the midwives of modern addiction treatment. It is among these advocates that the need and call for this recovery paradigm is most poignantly articulated. The advocacy leaders in local alcoholism and "drug abuse" councils were inspired by a vision of an ever-expanding recovery community. They championed the birth of professionally-directed treatment as a special doorway of entry into that community for the many people who could not make the transition from addiction to recovery on their own. Decades later, these advocates see an ever-growing treatment industry that views recovery as an afterthought or adjunct of itself. While this view may seem harsh to the readers of *Counselor*, consider the world through their eyes. They see "addiction studies" curricula in colleges and universities but no "recovery studies" curricula. They see scientific journals whose names reflect an interest in alcohol and other drugs (e.g., *Journal of Studies on Alcohol*, *Journal of Psychoactive Drugs*, *Addiction*, *Contemporary Drug Problems*) and professional intervention into AOD problems (e.g., *Journal of Substance Abuse Treatment*, *Alcoholism Treatment Quarterly*), but they see no peer-reviewed journals focused on the scientific study of addiction recovery. They read innumerable studies that meticulously describe who uses which psychoactive drugs and with what consequences, but see only a few recovery prevalence studies. They confront the public perception that people do not recover despite rarely acknowledged epidemiological studies finding that 58% of

people with lifetime substance dependence eventually achieve sustained recovery (Kessler, 1994; see also Dawson, 1996; Robins & Regier, 1991). They see national institutes of “alcohol abuse and alcoholism” and “drug abuse” and national centers of “substance abuse prevention” and “substance abuse treatment” but they see no “national institute/center of addiction recovery.” They see “addiction technology transfer centers” but no “recovery technology transfer centers.” In short, they see a field that knows a lot about addiction and a lot about treatment but which they perceive to have lost its focus on the goal and processes of long-term recovery.

These advocates are joining with visionary policy leaders, treatment professionals, and the addictions researchers to shift the field’s kinetic ideas and slogans from the nature of the problem (“addiction is a disease”) and the alleged effectiveness of its interventions (“treatment works”) to the living proof of a permanent solution to AOD problems (“recovery is a reality”). Collectively, these voices are saying that it is time to use the foundations laid from the study of the problem and its treatment to build a fully developed recovery paradigm.

The Recovery Paradigm

The movement forward to a recovery paradigm is already underway. The evidence of this shift in grassroots communities includes the:

- growth and diversification of American communities of recovery (White, in press)
- emergence of a multi-branched new recovery advocacy movement (White, 2001)
- rapidly spreading Wellbriety movement in Indian Country (see www.whitebison.org)
- growth of faith-based recovery support structures, particularly within communities of color (see Sanders, 2002)

- organization of recovering ex-felons into mutual support networks, (e.g., the Winners Circle in Chicago)
- growth of self-managed recovery homes (see <http://www.oxfordhouse.org>) and recovery schools (e.g., the Association of Recovery Schools), and the
- spread of recovery employment coops (e.g., Recovery at Work in Atlanta).

The shift to a recovery paradigm is evident at the federal level in President Bush’s Access to Recovery Initiative, increased NIDA and NIAAA support for studies of long-term recovery, and CSAT’s Recovery Community Support Program and Recovery Month initiatives. It is evident in state initiatives pushing treatment toward a “recovery-oriented system of care” (see <http://www.dmhas.state.ct.us/policies/policy83.htm>). It is evident in the research community’s call to shift addiction treatment from serial episodes of acute intervention to models of sustained “recovery management” (McLellan, Lewis, O’Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002, 2003). And it is evident in local experiments with peer-based models of recovery support, new recovery-focused service roles (recovery coaches, recovery support specialists), and the shift from traditional “aftercare” services to models of “assertive continuing care” (White & Godley, 2003; Dennis, Scott & Funk, 2003).

Recovery Management

How will the transition toward a recovery-focused future differ from our past? The shift from acute intervention to recovery management for those persons with severe and persistent AOD problems will involve three changes in the continuum of care.

First, it will intensify pre-treatment recovery support services to strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, and determine whether the individual/family can initiate and sustain recovery at this stage without additional professional intervention. (The latter may be quite possible for those with lower problem

severity and indigenous supports for recovery.)

Second, recovery management will intensify in-treatment recovery support services to enhance treatment retention and effects (by keeping treatment recovery-focused). Traditional treatment methods will change in a number of important dimensions (e.g., from single-agency to multi-agency intervention, from categorical to global assessment, from institution-based to neighborhood- and home-based service delivery). Most importantly, it will differ in the nature and duration of the service relationship.

Third, recovery management will shift the focus of treatment from acute stabilization to support for long-term recovery maintenance. Professionally-directed recovery management, like management of other chronic health disorders, shifts the focus of care from one of admit, treat, and discharge to a sustained health management partnership.

This means that the traditional discharge process will be replaced with post-stabilization monitoring (recovery check-ups), stage appropriate recovery education, recovery coaching, active linkage to communities of recovery, recovery community resource development, and, when needed, early re-intervention. Rather than cycling individuals through multiple self-contained episodes of acute treatment, recovery management provides an expanded array of recovery support services for a much greater length of time but at a much lower level of intensity and cost per service episode.

A New Language

New paradigms bring new ways of perceiving, thinking and speaking. As we move deeper into this recovery paradigm, we will need to forge new concepts and a new language. We will need better words and concepts to:

- delineate the conceptual boundaries of recovery

- describe types of recovery, e.g., partial versus full, serial recovery, solo versus assisted, medication-assisted recovery
- evaluate recovery assets, e.g., Granfield and Cloud's (1999) concept of "recovery capital"
- chart the pathways of recovery, e.g., secular, spiritual, religious
- distinguish styles of recovery initiation, e.g., incremental versus transformational change
- depict variations in identity reconstruction, e.g., recovery-positive versus recovery-neutral identities, and
- describe variations in recovery relationships (with other recovering people, e.g., acultural, bicultural and culturally enmeshed styles) (see White, 2002 for a detailed discussion of this new language).

We will all need to stretch our understanding of recovery and become multilingual as we expand the words and metaphors that reflect the growing varieties of recovery experiences in America.

A New Vision

Since its inception, the purpose of this column has been to enhance the addiction professional's understanding of the history of treatment and recovery in America. This article is about the living history that is unfolding before us in this moment. It is about the opportunity for recovery advocates, policy leaders, treatment professionals and researchers to form a partnership that will write the future of history of addiction treatment and recovery in America. Destiny will call some of you reading this to help lead this leap into the future. I wish you and your clients Godspeed on your journey from the problem we know so well to the recovery vision that lies ahead of us.

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