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Treatment, Recovery, Community: A Call for Reconnection

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The relationship between treatment agencies and the local communities in which they are nested has undergone significant changes over the past forty years. This essay reviews the nature of these changes and calls for a renewal of the linkage between treatment, recovery and community.

Interconnectedness of Treatment and Community

During the 1960s and 1970s, many factors contributed to a close relationship between newly birthed addiction treatment organizations and the local communities they served. Many of the citizen advocates who had volunteered in the local alcoholism and drug abuse councils that preceded the formal opening of local treatment organizations migrated into board and staff positions within these new agencies. This historical continuity exerted pressure to remain faithful to the founding vision of recovery-focused service interventions. Such accountability was further enhanced by the fact that local funding—dollars directly allocated from county or township boards and city councils, local contributions of goods and services and local donation of dollars--constituted an important portion of the budgets of early programs. The power of local communities was further enhanced by their review, comment and, in some cases, approval authority for all federal and state requests for funds to provide addiction treatment services. In some parts of the country, local counties, townships and cities were the actual recipient of treatment dollars that were then allocated to one or more not-for-profit treatment service providers.

The emerging service systems prioritized their ultimate loyalty as follows: 1) individuals and families in need of treatment services, 2) local community institutions, e.g., the criminal justice system, the health care system, allied human service agencies, and finally, 3) the growing funding and regulatory agencies overseeing addiction treatment. The struggle for legitimization of addiction treatment organizations (via licensure and accreditation) and addiction treatment personnel (via credentialing and certification) was initially focused on building professional credibility in the eyes of the field's most important consumers: local citizens and their families as well as local service institutions.

There was a similarly close relationship between many early treatment programs and local recovery mutual aid societies, particularly

Alcoholics Anonymous and Al-Anon. Many programs relied on a large cadre of AA and Al-Anon volunteers, met regularly with Hospital and Institutions Committees of AA, worked closely with AA sponsors, recruited staff from within the local recovery network, and expected staff (those with and without recovery backgrounds) to participate in the meetings of the local recovery community. Many budding treatment programs served as a hub of the local recovery community, with community rooms of treatment programs providing local people in recovery opportunities for fellowship and service. This close relationship between professional and indigenous recovery support organizations was not without its problems, but these were generally resolved through a growing folklore carried by the elders of these respective but overlapping communities.

This high level of interaction with the local community infused early addiction professionals with a detailed knowledge of indigenous sources of recovery support, kept staff closely linked to local service agencies and kept staff linked to the lives of their clients following primary treatment. The latter was particularly important in connecting the process of treatment intervention to the larger and more enduring process of long-term recovery. What staff of this era lacked in technical skill was made up for by their deep understanding of the healing, transformative power of participation in a community of shared experience, strength and hope. An organizing vision of early programs was to bring recovery within the very heart of local institutions (jails, hospitals, businesses, schools, community centers, churches, social service agencies) in a way that would amplify this healing power of the community.

The earliest role of counselor was not one of psychotherapeutic healing but a guide who led those wounded by alcohol and other drugs into participation with local communities of recovery whose supportive relationships were equal, reciprocal, enduring and non-commercialized. Many early addiction service organizations of the 1960s and 1970s developed a unique blend of clinical, community development and community organization models of intervention. Within these hybrid models, addiction treatment agencies were not the first line of defense in response to alcohol and other drug problems; they were the final safety net to help the community address those most severe and complex problems that could not be resolved through natural resources. However the solution even to these most severe problems emphasized the power of community (Mulford, 1976; White, 2002, 2003).

The Forces of Disconnection

In most parts of the United States, the connection between treatment, recovery and community peaked in the late 1970s and 1980s and then faded throughout the 1980s and 1990s. Several factors contributed to this disconnection process.

Aging of the Modern Alcoholism Movement: The leaders of the modern alcoholism movement spent lifetimes laying the foundation for a national network of addiction treatment programs. As these pioneers aged throughout the 1970s and 1980s, their representation on boards of treatment organizations diminished. The new board member of this era brought, not a history of recovery advocacy, but the political, economic, managerial and legal acumen to guide grassroots service agencies into maturity as formal organizations. As treatment agencies grew up (achieved professional autonomy), there was a tendency to separate themselves from the community-based social movements from whence they came.

Professionalization of Addiction Counseling: Efforts to move the addiction counselor from the role of “paraprofessional” to a legitimate service professional propelled counselor credentialing, certification and licensure movements. These movements elevated the knowledge and skill base of addiction counseling but inadvertently weakened the perceived role of community in recovery. Counselor training programs espoused “biopsychosocial” philosophies but were focused primarily on clinical models of intervention that paid little attention to the physical and cultural ecology of addiction and recovery. The community alcoholism consultant gave way to the counselor as a specialized addiction psychotherapist. At the same time, new ethical and clinical guidelines discouraged counselors from self-disclosing their own recovery status/story and cautioned counselors about “dual relationship” problems that could

arise in their professional/peer relationships. The elevation of the role of addiction counselor separated the counselor from the client and the treatment agency from both local communities of recovery and the larger civilian communities.

Confidentiality and Privacy: The stigma attached to alcohol and other drug problems was so great in the mid-twentieth century that the addictions field posited confidentiality and privacy assurances as a requirement for effective treatment. The resulting federal and state regulations and ethical codes generated the most restrictive confidentiality assurances in the history of health care. The increased professionalization of the treatment environment and tightening regulations related to confidentiality ended the previously open door policies through which many treatment facilities had served as drop-in centers for local people in recovery. These same factors contributed to the demise of once vibrant volunteer programs that had served to guide clients into relationships with local communities of recovery.

Industrialization of Addiction Treatment: What credentialing did for the addictions counselor, program licensure and accreditation did for the addictions treatment agency. The vision of the fledgling programs of the early 1970s was that accreditation (through the Joint Commission on Accreditation of Hospitals) would bring institutional credibility and open the flow of insurance money to support addiction treatment. We became obsessed with regulatory compliance and inadvertently elevated accountability to regulatory agencies over accountability to our clients and communities. What had in its infancy been a world focused on clients and local community need quickly became a complex world of federal and state agencies, accreditation bodies, and state and national professional associations. The treatment field, birthed as an adjunct to local communities of recovery, had become a bona fide industry.

Funding Influences: The weakening connection with local communities accelerated under the influence of changing patterns of funding for addiction treatment. As federal and state funding and third party insurance came to dwarf local contributions, addiction treatment agencies shifted their energies to responding to the demands of these external entities and away from maintaining close working relationships with local communities. Many local communities who at one time had approval power over the allocation of treatment dollars lost this authority as many states centralized funding decisions in the state bureaucracy. Local communities in most areas even lost their perfunctory review and comment role in such funding.

Changing Organizational Identity: Sometime in the 1980s, addiction treatment programs stopped being “community-based social service agencies” and became “behavioral health care businesses.” For too many organizations, accountability within this new business orientation was measured, not by fidelity to one’s founding vision or local service responsiveness, but by the organization’s financial profits or losses. In this climate, a program director was less likely to be asked about the recovery rate of his or her program than about the census or the profit margin of that program. This business and profit orientation has now reached such a state of excess that the non-profit status of some addiction treatment organizations could be legally challenged. In the for-profit addiction treatment community, little motivation exists to respond to local community needs as few of the patients entering these facilities come from these communities.

When the financial backlash of the late 1980s and early 1990s led to the closing of many residential and inpatient programs, many of the surviving programs expanded their geographical service areas. Such expansion weakened the influence of the local communities in which these organizations were located. For example, Chestnut Health Systems has gone from a handful of staff serving one county in 1973 to an organization that today has more than 600 employees providing services around the world—a transformation that has us pondering how precisely we define community accountability.

The professionalization and industrialization of addiction treatment have inadvertently weakened the relationship between professionally-directed addiction treatment and the long-term processes of recovery as well as the linkage between these experiences and indigenous community institutions. The loss of our founding leaders and their guiding vision has also contributed to this process of disconnection.

Back to the Future: A Call for Reconnection

There are many emerging forces that will push addiction treatment organizations to rebuild community relationships.

The New Recovery Advocacy Movement: There is a growing grassroots recovery advocacy movement in the United States. These local grassroots organizations are holding local treatment providers to a higher level of accountability than has existed for decades. When recovery advocates and addiction treatment leaders join together, they envision a seamless connection between addiction treatment and the larger, more enduring, and more community-influenced process of addiction recovery.

Competition for Shrinking Resources: National, state and local economies combined with war-related expenditures and growing budget deficits are creating pressure to cut domestic programs. There will be growing competition for resources and struggles to achieve priority status in these circumstances. To position itself within this environment of increased vulnerability, the addictions field will need to rebuild its grassroots constituencies. Service arenas that can only defend themselves through the voices of those with financial interests in these institutions will not fare well in this environment. Priority status will go to those arenas that demonstrate strong community (as well as broad political) support for their continued funding.

Recovery Outcomes: Independent funders and brokers of behavioral health services will exert similar pressures for involvement in the community but for quite different reasons. There is growing evidence that long-term recovery outcomes are shaped as much, if not more by what happens after treatment as what happens during treatment. This evidence supports post-treatment monitoring, sustained recovery support services, assertive linkages to indigenous communities of recovery, and early re-intervention. Insurance companies and managed behavioral health care firms will exert pressure for strong community relationships simply because those relationships are a crucial predictor of long-term recovery outcomes and reductions in health care costs.

Implications for Addiction Professionals

So where does this push for reconnection with community leave us? It is time we added our own voice to calls for addiction professionals to move out of our closed professional and social worlds and vibrantly re-enter the lives of our local communities. We can become students of the growing variety of recovery support structures. We can become members of local recovery advocacy organizations. We can advocate within our own organizations for a renewed relationship to the multiple community constituents we serve. We can become more visible ambassadors of our field within these communities. We can serve as recovery witnesses to the larger culture, sharing stories at every opportunity about lives transformed by addiction treatment and recovery. We can try to reconnect treatment, recovery and community.

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