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Toward a Core Recovery-focused Knowledge Base for Addiction Professionals and Recovery Support Specialists

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Arthur C. Evans, Jr., PhD
Commissioner
Philadelphia Department of Behavioral Health and Intellectual disAbilities Services

Recovery is emerging as a new organizing construct within the alcohol and drug problems arena. Government policymakers are reframing policy goals beyond those of supply reduction, harm minimization, and demand reduction. Discussions of primary prevention, early intervention, and clinical treatment are being reframed within a larger rubric of personal, family, and community recovery; wellness; and quality of life. Acute and palliative care models of addiction treatment are giving way to models of sustained recovery management nested within larger recovery-oriented systems of care. Clinical assessment and service planning are being revolutionized via the constructs of recovery capital and recovery planning. Multiple pathways of long-term recovery are being mapped within and across an ever-growing network of religious, spiritual, and secular recovery mutual aid societies and a greater understanding of processes of natural recovery. Grassroots recovery community organizations are springing up across the globe in an unprecedented level of cultural and political mobilization of individuals and families in recovery. New service institutions are emerging—recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes—that do not fit the traditional categories of addiction treatment and recovery mutual aid. Internet-based and other technology-based mutual aid and social networking are challenging traditional mechanisms for delivering both treatment and recovery support. New recovery-focused service roles are rapidly spreading, e.g., recovery support specialists, recovery coaches, peer specialists. And calls for pursuit of a recovery-focused research agenda are challenging the historical addiction pathology preoccupations of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

Support for recovery as an organizing paradigm has not been universal. Critics representing diverse interests have contended to the authors that the recovery concept is 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"), unscientific ("Are there evidence-based recovery practices?"), impractical ("No one will fund long-term recovery support."), and dangerous ("Recovery is a political Trojan horse whose real aim is de-professionalizing, delegitimizing, and defunding science-based addiction treatment and harm reduction services" (also see Davidson et al., 2005; Kirk, 2011). Each of these critiques must be challenged if recovery is to prove and sustain its value as a governing vision for the field. The authors have argued in a long series of papers, monographs, books and professional presentations that a true long-term recovery orientation will require a radical transformation of how addiction treatment and recovery support services are planned, designed, delivered, and evaluated (For a synthesis of these, see White, 2008a). But recovery's life expectancy as an organizing construct could indeed be limited if recovery and recovery-oriented practices remain ill-defined or if the recovery concept is hijacked and its meaning diluted or distorted to protect prevailing ideologies and institutional interests.

The next stage of the "recovery revolution," if it is to really be that, is to define in extremely concrete terms what recovery is and is not, how recovery orientation changes prevailing practices in addiction treatment, how new recovery roles differ from the service roles that preceded them, and what recovery-focused benchmarks should be used to evaluate role performance, organizational performance and systems performance. The present paper is part of a series of papers through which the authors wishes to contribute to this definitional work. The focus of the present paper is the following question:

Is there a core recovery-focused knowledge and skill set that distinguishes recovery-oriented addiction treatment and long-term recovery support services?

Table 1 below compares core areas of knowledge and skill that have constituted the historical education and training of traditional addiction professionals with core areas of knowledge and skill the author believes constitute an essential foundation for the delivery of recovery-oriented care and support. The first column of Table 1 represents topical areas addressed through mainstream addiction research activities, the curricula of addiction studies and addiction counselor training programs, addiction professional certification and licensure program standards, and the knowledge and skill sets used to screen, hire, train, and supervise addiction treatment professionals. This specialty knowledge is well-illustrated in publications such as the Center for Substance Abuse Treatment's Tap 21: *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*.

The second column of Table 1 notes recovery-focused ingredients that have been missing and that would need to be addressed in any move to increase the field's recovery orientation. The citations in column two illustrate publications that have attempted to address some of these historically neglected areas. These citations are not intended to be comprehensive but rather are included to illustrate that there are starting points on which to build this recovery-focused knowledge and skill base.

It is our contention that the core knowledge and skills outlined in column two constitute essential aspects of what should be included in the education, training, and ongoing supervision of all addiction treatment and recovery support specialists. Much of the recommended knowledge base does not currently exist and will not exist until federal, state and private research agendas are expanded to include critical recovery-focused questions. However, as the citations in column two suggest, sufficient knowledge

is available to begin this shift toward more recovery-focused training of addiction professionals and recovery support specialists.

Table 1: Contrasting Pathology-focused Medical/Clinical Paradigms and a Recovery Paradigm of Education and Training of Addiction Professionals and Recovery Support Specialists

Present Education/Training Focus	Missing Recovery Dimensions
Ways of knowing (scientific, professional, clinical knowledge); credibility and status based on educational, professional, organizational credentials/titles. Affirmation of the power and importance of science. Resources for accessing addiction-related research and literature.	Ways of knowing (experiential knowledge Borkman, 1976; Jackson, 2001, and cultural knowledge, Brady, 1995); credibility and status based on personal story/character and vetting as a healer via the community "wire"—a paperless credential no academic institution or professional certification body can bestow (White & Sanders, 2008). Acknowledgement of the limitations of science. Resources for accessing indigenous institutions and healers and experience-based and culturally-grounded recovery literature.
Problem definition, e.g., addiction & its defining elements; diagnostic criteria, e.g., APA DSM-V, WHO ICD-10.	Solution definition, e.g., personal/family/community resilience, resistance, & recovery & their defining elements (Betty Ford Institute Consensus Panel, 2007; Laudet, 2007; White, 2007; McLellan, 2010; SAMHSA, 2009, 2011; United Kingdom Drug Policy Commission, 2008); recovery measurement tools, e.g., paucity of validated DSM/ASI counterparts for assessing recovery status, stage of recovery, & recovery support needs.
Emphasis on assessment of problem severity/complexity (dozens of screening and assessment instruments, e.g., ASI, AUDIT, CAGE, CRAFFT, DAST, DUSI-R, GAIN, MAST, SCID) and models for level of care placement.	Emphasis on, but paucity of, instruments for assessment of personal, family, & community recovery capital (Groshkova, Best, & White, 2012; White & Cloud, 2008).

Present Education/Training Focus	Missing Recovery Dimensions
History of drug use/addiction & history of addiction treatment as a cultural institution.	History of addiction recovery, including modern diversification of recovery mutual aid organizations, the new recovery advocacy movement, growth of grassroots recovery community organizations and other new recovery support institutions (e.g., recovery homes, recovery schools, recovery industries, recovery ministries, recovery community centers, recovery cafes, recovery activities in sports, music, theatre, film) and technology-based recovery support resources (e.g., Internet-based mutual aid and recovery-supportive social networking; smart phone applications for recovery support; Humphreys, 2004; Kelly & White, 2012; For extensive citations, see White, 1998; 2000a, 2000b; 2001, 2004, 2006, 2007, 2009; White, Kelly, & Roth, 2012).
Pharmacology of drugs/neurobiology of addiction. Medical aspects of addiction, e.g., relationship between addiction and disease.	Neurobiology of addiction recovery (Erickson & White, 2009), pharmacology of medications used within addiction treatment (Abraham et al., 2009; Edwards et al., 2011; Garbutt, 2009; Knudsen et al., 2011; Rieckmann et al., 2007; White, Parrino, & Ginter, 2011), & medical aspects of recovery (temporal norms related to renormalization of sleep, energy, appetite, cognitive functioning, sexual functioning, and improvement/alleviation of addiction-related health problems, e.g., van Eijk, et al, 2012). Relationship between recovery and health.
AOD-related problem prevalence—review of community AOD use prevalence surveys (e.g., Monitoring the Future; National Household Survey); patterns of substance use drawn from national data systems profiling persons entering addiction treatment (e.g., SAMHSA—TEDS); other AOD-related casualty data, e.g., death data, arrest data, ER admissions, social cost data, etc.; this near-exclusive focus on problem prevalence and severity contributes to stigma-laden stereotypes of addiction and fuels cultural and therapeutic pessimism about the achievement of long-term recovery.	Solution prevalence—remission/recovery prevalence patterns drawn from community and clinical population surveys; profiles of people in recovery by demographics, primary drug(s); special populations, e.g., veterans, persons with co-occurring medical & psychiatric disorders; health profile/needs of people in recovery; community contribution profile of people in recovery via employment, income/taxes, service, etc. (Dawson, 1996, 1998; Dawson et al., 2005, 2006a, 2006b, 2007, 2008; ; Kessler et al., 1994, 2005; White, 2012); Emphasizing solution prevalence data raises cultural optimism and personal/family hope for recovery.

Present Education/Training Focus	Missing Recovery Dimensions
Pathology & intervention paradigms—theories of addiction; models of addiction treatment and theories of counseling; emphasis on the psychology of addiction & role of professional treatment in recovery initiation. Presentation of harm reduction (HR)models (theory and representative programs) as an alternative to addiction treatment and recovery support	Recovery as an organizing paradigm (Berridge, 2012; El-Guebaly, 2012; Elise, 1999; Morgan, 1996; White, 2004, 2005, 2008; Zweben, 1986); theories of recovery (Biernacki, 1986; Frykholm, 1985; Klingemann, 1991; Prochaska et al., 1994; Waldorf, 1983; Waldorf et al., 1991; White, 1996). Models integrating HR with treatment and recovery within an addiction / treatment / recovery careers schema (see Dennis, Scott, Funk, et al, 2005; Hser, Anglin, Grella, et al, 1997; Kellogg, 2003; Kellogg & Kreek, 2005; Marlatt, Blume & Parks, 2001; McLellan, 2003).
Short-term expert relational model—focus on brief hierarchical relational model drawn from brief psychotherapy role practiced by psychiatrists, psychologists, and social workers; emphasis on maintaining power differential and professional distance; rigorous boundary maintenance; prohibition on dual relationships; discouragement of self-disclosure.	Long-term partnership relational model; emphasis on system-wide relationships built on moral equality and emotional authenticity; reduced power differential; and value of recovery support relationships that are natural, non-hierarchical, reciprocal, enduring, and non-commercialized (White, 2008a; Lamb, Evans, & White, 2009).
Emphasis on treatment/recovery as a process of incremental change (e.g., stages of change and use of motivational interviewing to enhance recovery initiation); assertion of addiction as a "chronic, progressive, relapsing disorder"; relapse portrayed as part of recovery; focus on relapse prevention and relapse management.	Potential for recovery as a process of transformational change that is sudden, unplanned, positive, and permanent (Miller & C' de Baca, 2001; White, 2004); any resumption of AOD use and related problems is viewed, not as part of the recovery process, but as part of the pathology of addiction (White, 2010); recovery prevalence data collected includes emphasis on the number of people in continuous recovery since their first recovery initiation; focus on recovery maintenance and enhanced quality of personal and family life in long-term recovery (Laudet, Becker, & White, 2009).

Present Education/Training Focus	Missing Recovery Dimensions
Techniques of individual, group, and family counseling that focus on enhancing autonomy and individuation, self-knowledge, self-development, self-assertion, self-control, self-confidence, and self-esteem ("treatment as a process of getting into oneself"), e.g., self is the solution. Emphasis on listening.	Recovery-focused reconstruction of identity, character, values, and relationships (White, 1996); recovery as spiritual self-transcendence, mutual dependence, humility, tolerance, respect, and service to others ("recovery as a process of getting out of oneself"; Kurtz & Ketcham, 1992), e.g., self ("I") is the problem; "we" is the solution. Emphasis on storytelling and power of mutual identification.
Idiopathic, person-focused perspectives on etiology of AOD problems & their resolution. Stages of substance use disorders (pathways of problem entry).	Ecological (historical, cultural, economic, and political perspectives on the etiology of AOD problems & their resolution (White & Sanders, 2008). Integration of clinical and cultural revitalization/community development perspectives, including techniques for engaging indigenous community leaders, mapping recovery community resources, mobilizing untapped recovery community resources, and hosting recovery celebration events; strategies and tactics for recovery-focused community education and pro-recovery policy advocacy (Johnson, Martin, Sheahan, Way, & White, 2009; Maguire, Sheahan, & White, 2011). Pathways, processes, styles, and stages of long-term addiction recovery (pathways of problem exit; See White & Kurtz, 2006b for a review).
Emphasis on role of personal, organizational, and professional characteristics in predicting short-term treatment outcomes.	Emphasis on role of family and social environment, community culture, and community recovery capital in predicting long-term recovery outcomes (Humphreys, Moos, & Cohen, 1997).
Pathological family adaptations to progression of addiction (encompassing whole system, family subsystems, and individual family members).	Family (as system, subsystems, and individuals) adaptations across stages of long-term recovery, including adaptations to what Brown & Lewis depicted as the "trauma of recovery" (Brown & Lewis, 1999; White & Savage, 2005).

Present Education/Training Focus	Missing Recovery Dimensions
Professionally directed treatment planning; growing emphasis on coercion, control, and compliance.	Person-directed recovery planning (Borkman, 1998); emphasis on role of choice in recovery and personal inclusion in decision-making related to recovery support needs (White, 2008b).
Cultures of addiction (limited review of peer influence on addiction initiation and maintenance within drug subcultures)	Cultures of recovery (White, 1996); emphasis on status and studies of contemporary indigenous recovery support institutions; review of how recovery experience is being expressed through pathway-specific and ecumenical cultures of recovery via symbols, rituals, language, values, art, film, theatre, internet-based social networking, music, sport, literature, history, and community service (White, 2008b, also see following sections at www.williamwhitepapers.com : Recovery Support Interviews, History of Recovery Mutual Aid, and Varieties of Recovery Experience.)
Techniques to support acute biopsychosocial stabilization, e.g., crisis intervention; detoxification; brief sequestration from culture of addiction; addiction-focused psychosocial education; short-term individual, group, and family counseling; orientation and encouragement for recovery mutual aid involvement; review of studies of AA and other recovery mutual aid on short-term outcomes of persons completing addiction treatment.	Techniques to support long-term personal/family recovery, e.g., emphasis on techniques for post-treatment monitoring, stage-appropriate recovery education; recovery support, and if and when needed, early re-intervention; emphasis on role of community in long-term recovery and potential role addiction professionals can play in later stages of personal/family recovery (Chi et al., 2011; Dennis, Scott, Funk, et al, 2005, 2012; Godley et al., 2007; McKay et al., 2004, 2005a,b, 2011; White, 2009); Review of studies of AA and other recovery mutual aid on long-term outcomes of treated and untreated populations (For reviews see, Kelly & Yeterian, 2008; White, 2009).

Present Education/Training Focus	Missing Recovery Dimensions
Role and risks of medications in addiction treatment and recovery.	Risks and benefits of medication in recovery initiation and long-term recovery maintenance (White & Torres, 2010); evolving attitudes of addiction professionals and recovery mutual aid groups toward medications in general and the pharmacotherapeutic treatment of opioid addiction in particular (See White, 2011; White, Parrino, & Ginter, 2011 for extensive citations); alternative recovery support structures for Opioid Treatment Program patients (Ginter, 2012).
Vulnerability of, and predictive risk factors for, "special populations"—women, youth, elderly, people of color, LGBT, people with co-occurring disorders, etc.	Resilience, resistance, and recovery of historically disempowered populations; presence of indigenous recovery capital within historically marginalized persons and communities (Coyhis & White, 2006).
Influence of patient cultural affiliation and personal/historical trauma on addiction & the counseling process.	Culturally indigenous pathways of long-term recovery across the life cycle; emphasis on potential for resistance (abstinence as a an act of cultural/political activism and personal/cultural survival), recovery, and resilience in the face of personal & historical trauma (Brave Heart, 2003; Brave Heart & DeBruyn, 1998; Brave Heart et al., 2011; Coyhis & White, 2006; Williams, with Laird, 1992).
Addiction/Treatment-focused patient, professional, and community education.	Recovery-focused patient, professional, and community education (White, 2001); stigma management as a critical recovery component for individuals, families, and communities (White & Torres, 2010).
Legal and ethical issues in addiction counseling; ethical values drawn from professional community, with emphasis on confidentiality and maintaining professional detachment—*appropriate boundary management*.	Cultural etiquette of working with diverse communities of recovery across diverse cultural contexts (Achara-Abrahams et al., 2012; White & Kurtz, 2006a; White & Sanders, 2008; White, Evans, Lamb, & Achara-Abrahams, in press); ethical values and cultural etiquette drawn from multiple communities of recovery—with emphasis on humility, love, service, discretion, and respect; knowledge of anonymity tradition and its multiple functions.

Present Education/Training Focus	Missing Recovery Dimensions
Interagency collaboration; emphasis on mechanics and etiquette of working with formal community institutions, e.g., key organizations, roles, procedures, language.	Collaboration with & assertive linkage procedures to recovery mutual aid organizations and rapidly expanding recovery community organizations, e.g. key organizations, roles, procedures, language.,; knowledge and skills in developing and mobilizing community recovery support resources (Humphreys, 1999; Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009; McKnight, 1995; Timko, DeBenedetti, & Billow, 2006; White, 2001, 2009; White & Kurtz, 2006; Williams & Laird, 1992).
Focus on Short-term Treatment Outcomes; role of addiction professional in primary treatment.	Focus on long-term recovery outcomes (White, 2012); role of addiction professional and recovery support specialists across the stages of recovery (White, 2006).
Frequent note of intergenerational transmission of AOD problems.	Discussion of potential role of recovery in breaking intergenerational cycles and parenting strategies for recovering parents that can reduce risks of AOD problems in their children (Arria et.al., in press; White & Chaney, 2012).

The above table is not meant to suggest opposing, mutually exclusive bodies of knowledge. It is instead a way to convey that we as a field have developed great expertise on alcohol and other drug-related problems, but lack a comparable body of knowledge related to the solutions to these problems as they exist today in the lives of individuals, families, and communities. It is time we moved beyond the superficial rhetoric calling for increased recovery orientation in the design of addiction treatment (and community-based recovery support services) and began the much harder work of building and then infusing a recovery-focused foundation of knowledge and skills into the education and training of addiction professionals, recovery support specialists and the broader arena of allied health and human service professionals. Work towards that goal is already underway.

About the Authors: William White is Emeritus Senior Research Consultant, Chestnut Health Systems; Arthur C. Evans, Jr., is Commission, Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

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