The Devolution of PRSS and the Lost Lessons of Earlier Eras

"The service commitment of recovering people can be exploited within rising or expanding systems of care in ways that undermine both role performance and the personal health/recovery of these workers. The modern system of addiction treatment was built on the backs of people in recovery, many of whom were then discarded through the professionalization and commercialization of addiction treatment." **William White - Lost Lessons from an Earlier Era**

William White wrote these words as part in 2014, reflecting on what had occurred in the era when public arena substance use treatment was founded and then expanded in the US in the 1970s. He was writing about how the very people who built the substance use treatment system were used and discarded as the focus of the field shifted into being an industry and away from a purpose driven mission to serve fellow members of their respective communities.

In [the piece on Lost Lessons from an Earlier Era], he considered how we could learn from what happened in that prior era in the evolution of our SUD Treatment system for peer services. Lessons that could have served in that moment a decade ago and through our current times to avoid the very same fate. He wrote this as Peer Recovery Support Services (PRSS) began to be embraced and expand across the United States in the early 2010s. His central question in the pieces was what experiential lessons from this earlier era could inform the present implementation of PRSS. He also references the seminal work he did on PRSS in his 2009 [Peer-based addiction recovery support: History, theory, practice, and scientific evaluation]. All who use terms such as recovery support services, recovery management and recovery-oriented systems of care should read his authoritative work in this area and consider that any modifications to these concepts should be done mindfully and with the full inclusion of the indigenous recovery communities that would be impacted to avoid harming them under the stated system auspices of help. Anything less is pure harm.

In our current era, the inclusion of recovery community in how these systems evolve is the exception to the rule. Government directly uses funds to provide peer services in isolation from community or the services are utilized within the related industries for profit or other utility not related to the needs and goals of the recovery community. This has the likely potential of undermining the very community our systems ostensibly claims to help. No system can assert progress with addiction or recovery related stigma while at the same time excluding recovery community in service conceptualization, implementation, evaluation or through tokenism of community members sprinkled in at the end of the process to provide the false appearance of authenticity. That is actually contempt for recovery community.

In his Lost Lessons piece, the quote above is point 5 of his writings, verbatim. The quote resonates with many of us who lived through that era. History shows us that after the recovery community was exploited and discarded by the substance use treatment industry, it itself lost its way. The professional treatment system to a significant extent could no longer connect people being served in these treatment systems with the recovery community. It had lost the capacity to translate the culture of recovery and transitioning treatment recipients into communities of recovery, which remains a vital task in our own era.

We must wonder as our current juncture if recovery community members are increasingly exploited and then discarded by the growing industries of peer support, fundamentally detached from the inclusion of recovery community in its own healing, what will the next generation need to reinvent to provide these vital recovery community engagement roles? Will they learn from our failures to heed history? White delineates 20 points of consideration, 14 through 18 in the Lost Lessons piece are as he authored below, in italics and bold font with thought of my own in regular font:

Professionalization of PRSS

14. ***The professionalization of PRSS can inadvertently diminish critical dimensions of peer recovery support, e.g., loss of recovery carrier role via prohibitions/limits on self-disclosure, reductions in mutual identification and its subsequent effects on engagement and retention, and loss of assertive linkage to communities of recovery***.

We are seeing such unheeded warnings of harm unfold as peer recovery services expand as an industry and not a community driven mission. Some of them are directly related to failures in these same systems to properly deploy people in these roles ethically and for maxim efficacy but instead for profit and short-term gain for these systems at the expense of the workers and the impacted community. New workers, barely out of training and with limited support through supervision or mentor roles are sent into profoundly challenging environments with death and traumatic situations all around them. It would be akin to asking a first-year med student to triage an ED in an urban hospital alone in their first hours of direct care. We would not think of doing that in medical care, it is routinely done in our space without the proper support and mentorship of these workers fresh into the trenches.

Once a "problem" develops such as a resumption of use because of the dynamics resulting from these harms, these same systems erect additional rules, barriers and training ostensibly to resolve the problem but failing to do so in ways that include assertive linkage to the impacted community. This sets up a passive model in which communities are mere recipients of over professionalized and homogenized care with less than recovery-oriented services. Services from which these industries squeeze out profits while the critical dimensions of PRSS and the value of those who provide it are greatly diminished. Workers not connected with the local recovery community increasingly tasked to maximize billing for services that fail to help people navigate into the healing arms of recovery community through a process of mutuality but simply cash in on sessions to meet financial goals established by investor groups. Services that fail to support more organic recovery community engagement as envisioned with recovery carrier champions as was the foundational vision.

15. ***Excessive professionalization and commercialization of PRSS roles can undermine the service ethic within indigenous communities of recovery resulting in long-term harm to the community in which such excesses occur***.

One of the critical dynamics that can be understood by even a casual read of recovery history is that service to others is a critical element of recovery for many, if not the majority of people in the recovery process without regard to recovery pathway. Mutual support and the capacity of communities to be the main element of the healing of its own members is necessary for community level recovery capital to flourish. It runs contrary to an industrial services orientation. Over professionalism and commercialization serves the servers and not the community, who become passive recipients of narrowly defined care not inclusive of their talents and energy. A form of robbery as the resources are capitalized by our formal institutions at the expense of indigenous recovery communities in all their diversity.

No entity engaged in such a process can consider themselves as contributive to this recovery community capital, but instead servants of stigmatic practices and paternalistic care as the community is treated as incapable of being meaningfully included in their own healing. Systems that turn communities into passive recipients of a system serving itself instead of the broad healing it could instead support though more meaningful and authentic collaborative action.

Ethics of PRSS

16. ***The ethical mandate for PRSS roles, like that of all helping roles, is to practice within, and only within, the boundaries of one's education, training and experience***.

The push to serve other purposes beyond the intended role of being a recovery carrier inside of medical, treatment or governmental institutions is overwhelming and ever-present. While these roles can and should evolve over time, it must be done in ways that are consistent with its aspirational vision of being grounded in the recovery community and the ethos of nothing about us without from which it originates. Without roots firmly grounded in the indigenous recovery communities these roles originate from us, they will inevitably and with certainty devolve into just another two-dimensional transactional paternalistic service to gain money for the institutions and loose the vitality of leveraging the collective talents and resources of the recovery community. We will fail to tap into our greatest asset, the power of community.

Loss of connectivity to the recovery community results in the elimination of recovery oriented steerage of the roles related thoughts and steering concepts I refer to in my piece, The Keel of the New Recovery Advocacy Movement. Failure to ground PRSS in the recovery community leads to the cooptation and colonization of the role by clinical functions and

for use by other entities operating as confederates with different agendas in our space. Groups that have agendas beyond strengthening recovery within communities across America in all their diversity and serve to derail our efforts.

17. ***The ethics and etiquette of PRSS need to be informed by core recovery community values and filtered through the cultural context in which such services are being delivered. Rule-based ethical mandates drawn from other professional disciplines cannot be arbitrarily imposed on PRSS roles without compromising their effectiveness. This is particularly true for those PRSS roles involved in assertive outreach and engagement or long-term recovery monitoring and support***.

Our history shows us that the development of the PRSS role came about because the clinical care system became detached from the very communities that they excelled at connecting people to in the early stages of the development of our treatment system in the 1970s. Failure to ground the ethics of PRSS in ways that are informed by core recovery community values invariably result in the loss of guiding principles. Services veering away from their intended role and dissolving into the dominant clinical orientations. Losing their vital role to connect and engage persons within recovery community. The very dynamics that William White prophetically cautioned about in his State of the New Recovery Advocacy Movement address to the leadership academy of Faces & Voices of Recovery in 2013. He noted that a recovery movement that became focused only on peer services was doomed to failure. This is in part because unless such services are grounded in the community movement, they lose their vitality and critically necessary focus and become just another treatment strategy to serve people within a limited transactional and hierarchical relationship.

18. ***The potential for the emotional, sexual and financial exploitation can never be completely eliminated within any helping relationship, but these risks can be minimized within PRSS through effectives systems of screening and selection, orientation and training and rigorous ongoing supervision***.

Exploitation is the result as the services are designed and funded yet persons in recovery in these roles are treated as line workers not authentically involved in shaping what becomes a recovery-oriented systems of care in name only. Nothing about us without us devolves into everything about us without us. A system of paternalistic care incongruent with its stated goals and values of healing at the individual, family and community levels. Systems of healing that use people like cannon fodder and throw any available body they can find on the front lines and then only valuing the ones who survive the horrific trial by fire dynamics. Blaming those who fail to thrive in such conditions and suffer the consequences of inadequate support as somehow being at fault for what these same systems failed to provide. Inadequate screening, training, support and peer supervision. Just another tired and repeated theme in our acute fragmented service delivery system that can proliferate harm to the helpers which in turn cascades into harm in the name of help to those in need of care. Systems designed around political goals or economic benefit for the involved industries at the expense of individual, family and community SUD healing.

In closing

Any casual review of the volumes of recovery history in America available to us for study reveal tensions between high value collaborative strategies of healing and the tendency for hucksters and hustlers to take advantage of the addicted for personal gain. From the great orators of the Washingtonian movement, through the chapters of the magic elixirs of healing such as the Keeley Cure to our current era, history is replete with promises of simple solutions and cures that ring in the ears of desperate people. Willing to do anything to be free of the ravages of addiction. The very lessons we would well heed to avoid the exploitation of our own people who become overshadowed by the forces of greed, power and fame. Forces that lead to more even devastation for all those who fall in its path. Exploited and cast out for others profit.

It has been said that the greatest lesson of history is that we do not learn from our history. This is true for recovery history as well. Readers may feel the weight of these words and our unheeded lessons as the consequences of not paying attention to what history has to teach us. The other lesson from history is that it is never too late to learn from our history. There is no time to do so better than right now.

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