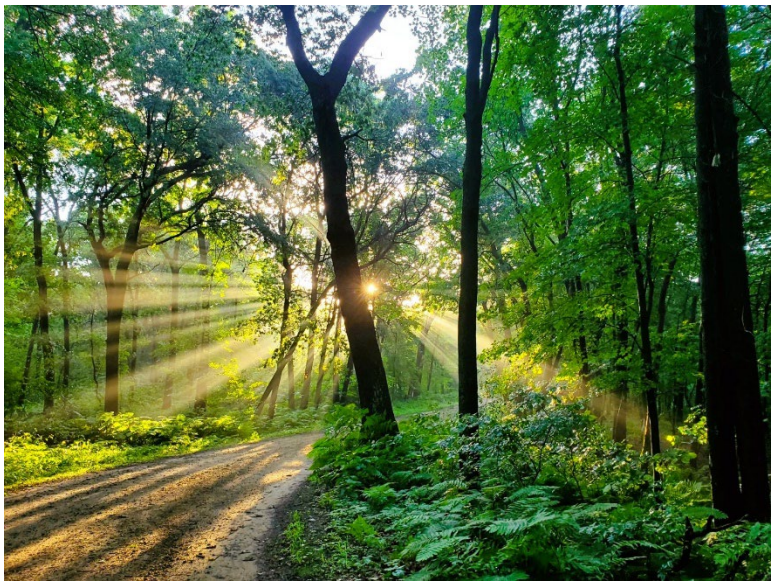
Ways of Knowing and Our AOD Treatment & Recovery Workforce



In the addiction and recovery space, we often fail to see issues and related solutions through multiple lenses. We want simple answers and even simpler solutions to our most profoundly complex challenges. The proverbial silver bullet solution that ever fails us. As my colleague Jason Schwartz writes, we have multiple approaches to addressing drug problems, from medical treatment, public health strategies, specialty addictions treatment, public policy solutions, recovery support strategies, community based responses and the strengthening of family supports. All necessary and all incomplete and dependent on the other strategies. We fail in part by seeing solutions focused on one or two facets of the problems and the solutions at the expense of the others.

The flaws of seeking simple solutions to complex challenges has very much been in my mind since Bill White asked me to present his comments which he has published, Frontiers of Recovery Research at the lead off the first annual 2024 National Conference on Addiction Recovery Science a few weeks ago. He noted in his eloquent way that we should embrace multiple ways of knowing within the quest to understand and resolve alcohol and other drug problems (AOD). White delineated four primary arenas of knowledge, or ways of knowing, exist within the AOD arena: 1) experiential knowledge, 2) common or public knowledge—popular folklore or myth, 3) professional/clinical knowledge, and 4) scientific knowledge. We have things to learn from in each arena and need to understand how each inform practice across the recovery process in our service settings and within our related AOD workforce.

The underlying truth is that there are no silver bullets. This is a maxim even as the scale and severity of the crisis intensify the desperate quest for silver bullets. Worse, the search for a silver bullet leads us astray and encourages each arena to present as the simple silver bullet solution. We tend to see scientific knowledge gained most often through academic institutions as that silver bullet. If we pile our field high with homogenized and degreed persons steeped in the current scientific arena of knowledge, we think these healing methods will prevail.

Degrees are how we typically measure learning, it is a necessary yet incomplete pillar of knowledge, dependent in the AOD sector on other pillars as the issues and solutions are complex and transcend what can be gleaned through this very necessary but also incomplete ways of knowing. These dynamics also play out in our substance use system workforce in which we hold academic pathways to knowledge as the sole way of knowing and discount lived and experiential arenas of knowledge. This is to our detriment and a direct result of bias for experiential knowledge which is vital to our institutions of healing.

In one of his most important pieces, the Historical Essence of Addiction Counseling in William White noted that “other professions conveyed to the person with a substance use condition that other problems were the source of addiction, and their resolution was the pathway to recovery. Addiction counseling was built on the failure of this premise. The addiction counselor offered a distinctly different view: “One could argue that a specialized addiction field was born in great part due to the contempt in which persons with alcohol and other substance use conditions where held by other helping professions…Whatever technical skill the addiction counselor may possess that is lacking in these other professions, that skill may not be as important as the addiction counselor’s ability to transcend this history of contempt.” (White 2004)”

The rise of the addictions counseling profession was the first iteration of the modern recovery movement. A movement born out of advocacy efforts of the recovery community in the late 1960s and early 1970s to establish a viable AOD treatment system. People in recovery and their allies rising up to provide care and support for people with addictions who have been jailed, neglected, lobotomized or electroshocked by our mental health and carceral systems. Held in deep contempt across these related fields. A contempt that was then and is now ever present. A contempt that is often

invisible to the care provider yet palpable viscerally to those of us with lived experience who work in our field and those who seek help for an AOD problem.

Our systems need people with experiential knowledge as a counterbalance to this inherent contempt for persons with AOD problems deeply ingrained across our society and all its formal and informal institutions. When we purge people with experiential lived experience knowledge or set barriers up to keep them out of the field, we actually reduce the impact of our collective efforts. That is our history.

We do not want it to be our future as well.

Although early on our care system had many flaws, the same of which can be said for our current care system. Infrastructure built by a deeply motivated and energized workforce dedicated to the work and helping their communities heal. As William White noted in a 2014 writing, Volunteerism and Addiction Treatment, a 1976 survey of the US addiction treatment workforce revealed a of nearly 60,000 workers. Of these workers, 31,000 were full-time workers and 15,000 part-time paid workers. The paid professional workforce included 20,000 counselors, 5,000 nurses, 3,000 social workers, 2,500 psychologists, and a small and slowly growing cadre of physicians. But most striking is more than 1,000 full-time volunteers and 13,000 part-time volunteers.

People were so eager to do this work as a calling, they volunteered! This group of workers were lost through professionalization, not just in the volunteer workforce but in the paid workforce as we set up barriers to the field for recovering people, eager to help and eager to learn. Our history also shows us that many of those who were able to get into the field ended up achieving advanced degrees and had command across multiple pillars of learning. I would suggest that these workers, grounded in experiential knowledge, who then gained academic credentials have long been the backbone of our workforce. Failure to understand how these workers have knowledge across these Pillars will result in profound challenges to our AOD problem workforce moving forward. We should be paying a great deal of attention to these dynamics.

The Broad Elimination of Addiction Treatment Programming and Loss of Fluency In Recovery Culture in the 1990s
Two major trends occurred in the 1990s that had a devastating impact on our capacity to support healing for persons experiencing severe substance use conditions. MCOs began to carve out care with lower financial incentives for intensive treatment. During this era as described in The impact of managed care on substance abuse treatment services, Substance use treatment coverage declined 75%, compared to 11.5% for general health care. This shift resulted in a drastic reduction in frequency and duration of inpatient care. There was no corresponding increase in outpatient care. As As a result, there was a profound negative impact on rehabilitation efforts for persons with substance use disorders. Many people died in this era because they could not access the care they needed. The contempt held in our society for persons with SUD problems led our society to blame the providers for these failures, even as the root cause of the problem was a system designed to provide less than what people needed to heal. A system designed to fail us.

In my home state, as the losses and devastation unfolded in that era, HBO filmed a clip titled HBO Addiction Clip Insurance Woes in our State Capital as part of a Documentary on Addiction depicting the impact of discriminatory insurance coverage on our state. Funders created byzantine and time intensive authorization processes with criteria often conflicting and confusing, all designed to fail the person in need and decrease treatment expenditures for the companies. Getting a person the right care for the right duration of time became a moon-shot level of effort for providers. Days of effort every time they attempted to navigate the myriad of administrative burdens and paperwork processes designed to grind them down and accept whatever meager care the funder wanted to dole out in arbitrary and capricious ways. Some stayed and fought for change. Yet, the field lost many competent and committed people who could no longer watch the people they dedicated their lives to help die from lack of proper care. Our field withered.

As this was occurring, the field also responded by attempting to over professionalize the workforce in ways that purged out recovering people. The very people who understood best how to connect those in care to the culture and communities of recovery because they were steeped in other ways of knowing beyond the academic pillar. Treatment became broadly ineffective in providing what people needed to heal as it lost the capacity to connect people in care to communities of recovery. The erosion of treatment by funders fueled the false narrative that we do not get better and are not worth the effort.

People in the recovery community began to form together to start the new recovery advocacy movement. To be a voice for people who needed services and move beyond the acute fragmented care model of the era. In this desperate era, the

seeds were being sown for what we now call the new recovery advocacy movement. Like a phoenix, they rose up and helped our care system to be reborn in a more effective way, in no small part by infusing our AOD care systems with people with lived experience. These arcs of history, arcs of decay and rebirth are vital for us to understand.

Students of our history can see echoes of repeating patterns across the decades. One of the facets of such deeply ingrained bias in our society is that those whose primary way of knowing are academic in manner is that the deeply held contempt across our society for persons who have experienced a substance use condition is not even detectable to them. Yet, in ways that are easily detectable to those of us with addictions. This contempt drives out people with lived experience from our workforce and from our AOD service institutions. A system that tends to consistently tilt back towards valuing academic pathways of knowledge, with all of its flaws and blind spots as the sole way of knowing. One that is necessary, but incomplete without the other pillars of knowledge.

The driving out of lived experiential knowledge within our current AOD treatment and recovery support workforce is a significant factor in our current failure to retain workers deeply committed and passionate about doing this work across career spans. We end up recruiting people for whom this is not a calling but instead a starting point. Workers who are competent in one pillar of knowledge who have no allegiance to the field or calling to serve people with AOD problems. Workers who move on to higher paid, lower stress work with fewer administrative burdens because the field is not their calling. In this manner, our current AOD workforce is losing its deep institutional knowledge critical to its future.

We cannot generate and sustain a field without a committed core of workers called to serve people in need across career spans. Called to the work and not a way point to other career goals. This is in part what I was writing about in Loss of Institutional Knowledge - a Critical Tipping Point in the SUD Workforce Crisis. This is occurring in our own era in ways that echo what unfolded in the 1970s. The vibrant volunteer programs of the 1970s faded in the wake of the field's growing professionalization and commercialization and the growing disconnection between addiction treatment "businesses" and the grassroots communities that had birthed them.

White noted that as volunteers disappeared from the addiction treatment milieu during the 1980s and 1990s, the story of their role in early addiction treatment and what they did to engage people seeking recovery also evaporated. Experiential knowledge was dramatically reduced. There was less understanding of how and where people recover that simply does not exist in books and academic learning processes. Far fewer people in the field who were fluent in both the culture of addiction and the culture of healing from and engaging people in recovery community. Those who could help people find healing through connection to community recovery capital, whose primary way of knowing was experiential with other pillars built on top of that one as they stayed with the work over a career span.

This is also playing out in our current peer support realm, which started as a mix of grassroots volunteer and paid positions and is now shifting to a corporate model in which groups race to make as much money that they can profit off the suffering of our community members. We will not sustain our field by focusing on the profit motive and professionalization based on academic learning in pursuit of being seen as legitimate in a society that still holds deep contempt for persons with AOD challenges. That lesson is clear from what happened in the 1990s.

Ways of Knowing and their Influence on The SUD Care System and Its Workforce

1. **Common or public knowledge / popular folklore or myth** – Communities develop knowledgebases over time. Understanding these pillars of knowledge can help us consider avenues to pursue scientific knowledge. Understanding the common or folklore in a community can support effective engagement strategies to address needs in those communities.
2. **Experiential knowledge** - As addiction is a complex condition, it is often communities that figure out what works for them well before academics document it and researchers measure it. People use the scientific method of trial and error to learn effective strategies to address them. This is why when there is an emerging drug trend, asking people directly impacted and on the ground can provide significant insight into how to effectively respond. Workers in these settings are highly skilled in adaptation to changing conditions irrespective of their academic achievements.
3. **Professional/clinical knowledge** – Professions develop ways of knowing and form disciplines based on their own conceptual frameworks, ways of communicating, measuring and conferring these bodies of knowledge to others. These disciplines form tribal groups who identify who can and cannot be recognized as a member of the discipline, sometimes in ways that are designed more to create conditions for monetary gain or high status at the expense of other disciplines. They all serve to drive people with lived experience out of the field as they focus on academic achievement and not other ways of knowing.

4. **Scientific knowledge** – We have pillars of knowledge based on the capacity to measure the outcome of an intervention through qualitative and quantitative research of varying degrees of rigor. What one measures and how it is measured can significantly alter the outcome. While this is an important pillar, we tend to overvalue it as it is subject to influence in a variety of ways. Who funds the research and what outcome would benefit that group are factors. Dominate groups set up as designs that can miss impacts on more marginalized groups. It can be dangerous to consider the outcome of a study to groups beyond those studied, with variables and factors not measured in the study design and to consider who stands to gain by the outcome.

I would humbly add a fifth way of knowing to what William White has articulated, an arena that he has vastly contributed to, and that arena is historical knowledge. This is not our first, second or even third cycle around this challenge to recruit and sustain a viable workforce to address the complex needs of persons with AOD challenges.

The lesson to learn is that we must embrace and include all ways of knowing in our field for us to be effective. We have echoes of past successes and failures that are with us into our own era and will be with us well beyond the spans of any of readers lives. We would do well to consider this arena.

As Lilly Tomlin once suggested, "Maybe if we listened, history wouldn't keep repeating itself."

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