

The Real Gold Standard Addiction Treatment

There has been a lot of focus over the years on what the “gold standard” of addiction treatment is. The simple truth is that the gold standard of addiction treatment is the one that most effectively fosters the conditions in which recovery flourishes over the long term. When we begin to think about it in that way, it becomes highly nuanced and individualized. The processes will widely vary dependent on cultural, religious beliefs, familial values, individual capacities and interests. This is why the true gold standard requires care that resonates with the recovery initiate in ways that develop a state of belonging, reciprocity, deep purpose and contribution that are sustained over the long term.



Recovery is sustained through belonging and social connection

The gold standard of addiction treatment should not be defined myopically by whether we can get a person to stop using substances. It is a standard of how we collaborate with them to rebuild a life in which recovery can be sustained. Historically, we have viewed and measured effective treatment using short term measures focused on whether a person stops using substances and complies with a prescribed episode of care. We know that addiction is not an acute condition; yet it remains a radical notion that strategies to support recovery must be more than short-term interventions.

Recovery is about much more than the subtraction of addiction from the equation. Recovery from a severe substance use condition typically requires effort and change sustained within community over a lifetime. Yet we treat it like we would a bad flu or an arm fracture. As Mark Sanders and I recently wrote about in [Revisiting the Article That Sent Shockwaves Throughout the Substance Use Disorder Profession](#), we do not even consistently measure recovery beyond acute care benchmarks. A gold standard of care would demonstrably result in long-term recovery. Interventions that sustain limited gain over the short-term simply cannot be considered as gold standards. They should be summarily rejected until they demonstrate significant improvements in global health and functioning that are durable over time.

Gold standard recovery processes must also account for the coproduction of recovery and not be recipient / provider oriented. Our traditional acute care addiction treatment programming far too often places the primary agency in the hands of the clinician, the medication, or the protocol, rather than the person or community group who are developing wellness methods that are durable over time. Engagement with others who are pursuing recovery provides a sense of belonging and helps people transform from an identity organized around addiction and isolation toward an identity as a valued member of a recovery community. In contrast, long-term recovery is fundamentally a social process: people build relationships, communities, identities, and environments that sustain durable recovery over time.

Reciprocity is a key facet of sustained recovery.

This reciprocity of effort is a deep truth long known by people in recovery. Broader application of this knowledge would transform from recovery support from a thing received into something reciprocated and passed on to others. People in recovery often need to become co-contributors, not perpetual recipients of services to sustain what they have gained. This knowledge, while long known within our broad community, has not been consistently applied across our formalized treatment systems built upon the provision of limited interventions to recipients. [Research on mutual-aid participation and social identity](#) supports the importance of group membership, identification, and self-efficacy in reducing relapse and strengthening recovery. Service innovations that strengthen reciprocal coproduced recovery processes run at cross purpose to the medical model. They tend to be extinguished or diluted over time. We then move back towards a conveyor belt unidirectional top-down service orientation. Programs using social model recovery strategies, which are evidence based, find they do so as work arounds to prescribed models of care instead of as the main event they really are in how recovery processes are fostered and sustained.

Treatment strategies that actively engage people in recovery are aligned with this [social model of recovery](#) as mentioned above have been found to be highly effective. We typically find these models in programs that align with the therapeutic community model and within recovery residencies, including Oxford Houses or indigenous community groups. Belonging and mattering. They build on reciprocity and coproduction of synergistic recovery processes. Being needed by another

person, sharing one's experience, mentoring a newcomer, volunteering, or helping to improve one's community is a regenerative process that sustains recovery. These activities provide opportunities to practice the very capacities that sustain long-term recovery which include being responsible, living with integrity, being reliable, having empathy and building connection with other people. These things help people reinforce a positive recovery identity together.

This is why models of recovery-oriented systems center on people and communities, not service providers and funders. We often see the application of these models that invert those dynamics and place the programming in the center of the circle. Processes that do that miss the mark entirely and are more oriented towards perpetuating our acute service framework. [Volunteering and socially oriented peer activities are associated with greater recovery capital](#) and improvements in self-esteem, psychological distress, and quality of life. Recovery capital is more of a community thing than an individual process.

Recovery is a long-term process not an acute intervention

Treatment can help people initiate change. Peer support can assist in guiding people to build community recovery capital. Yet, to be effective beyond the short-term, service and support providers need to help people firmly establish deep foundations in recovery community. Our funding and service criteria need to support processes that connect people to community and include reciprocity within the service milieu. Durable recovery processes foster relationships, meaningful roles, mutuality, civic engagement, friendship, belonging, and a deep sense of purpose. The gold standard is not lifelong treatment dependence; it is lifelong recovery participation that transitions people from receiving support to participating in community, to becoming sources of support, leadership, meaning, and hope for others in their own right.

There is nothing really earth shattering in this essay. Every concept has been articulated by many people over generations of effort to transform our systems of care into a gold standard, durable community grounded framework. It is also true that like a mirage of an oasis in a vast desert, we never quite get there. When we get close, the vision dissipates into parched sands.

We know that recovery can be a long process. We also know that recovery is the probable outcome when people get the services and supports, they need to sustain recovery. 85% of the people who get to five years of recovery stay in recovery for the rest of their lives. One might hope that our systems would be designed around what we know about addiction and recovery, that recovery takes time and varied high intensity and low intensity services as well as coproduced processes to build community recovery capital. Yet, we do not have a system designed around what we know about addiction recovery. We have a system designed around acute, narrow definitions of effective intervention not integrated into long-term recovery trajectories. We don't even follow people routinely. Can you imagine if this was the system design for oncology? Each intervention is a separate process that lacks integration into pathways that build momentum along long-term trajectories of resolution. If we treated cancer this way, most people would die. In this scenario, remission may be possible but far from probable.

Low Expectation Oriented System

We have a system designed to develop relatively brief interventions in ways that produce poorer results than would occur if we had a system of care designed like oncology treatment systems. The difference is that we have a system designed around low expectations of recovery. Dr Justin Bell recently wrote about how poorly resourced treatment centers overwhelmed with the needs of the people they are serving [turn into assembly lines](#). Dr. Bell noted in his essay that the people who delivered the care were committed and motivated to do a good job. This is what I have also observed in my travels through programming across the nation. Another way to look at what he is articulating is that these programs are functioning as triaging centers rather than treatment centers. Places where there are simply not enough resources to treat everyone to the extent that they need but the grim rationing of time and resources to do the best they can with more people served for shorter durations and lower intensity of care than they need to get better.

The workers are generally not careless people trying to deliver poor services, quite the opposite, they are doing what any care system would do given too few resources and too little time to do the work they need to do properly. While the oft played narrative portrays the challenge we face as a case of bad providers providing poor services, our challenges are much deeper than that all too convenient narrative. We do not treat addiction in an evidence-based way because our service systems are not designed to deliver care in that way. To deliver gold standard care, we must have a system of care designed to deliver long term recovery. We do not have that in America, particularly in our insurance models of care.

A generation ago, recovery advocates and researchers like Dr. Tom McLellen and his colleagues imagined more for us. A shift from an acute care model to one that reflected the chronic nature of addiction in their 2005 paper [Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring](#). We have failed to build it. The challenge is about more than resources; it is about the prevailing low expectation of recovery within our society. This is something that William White wrote about in his paper on Post Traumatic Growth and Flourishing in Addiction Recovery. He noted that “addicted people die of addiction, but they also die from a lack of hope fed by cultural pessimism about the prospects of long-term recovery—deaths of low expectation (page 87).”

All that Glitters...

Any isolated intervention, medication or service portrayed as the gold standard is nothing but fools’ gold. Real gold is recovery that results in global improvements in health and functioning that are durable over time. It says everything about our entire system of care that we do not establish this sole gold standard. There are things we know about what it would take to deliver gold standard care and support we just do not do it. The processes would be highly individualized, culturally nuanced and allow for multiple interventions and strategies with varying intensities across the care process and support continuum over a minimum of five years from the point of initiation.

If our society truly believed in recovery, we would support synergistic, individualized and highly nuanced recovery processes that are durable and measured over the long term as the gold we gain. It is time to do so.

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