

History Repeating – the “Opioid” Epidemic Supplanting the Recovery Movement: Pathology Over Resiliency and Healing

“The historical sense involves a perception, not only of the pastness of the past, but of its presence”

— T.S. Eliot, Four Quartets

The [New Recovery Advocacy Movement](#) got off the ground in America roughly three decades ago, during a time when addiction recovery policy and practice had fundamentally lost its way. In that era, it was far easier to incarcerate a person for addiction than to help them heal. Treatment was brief and detached from communities of recovery. The field had moved away from its lived experience-based understanding into a primary focus on academic knowledge of addiction, which was wholly isolated from what these very same communities had learned through experience in real world conditions worked to support long term healing. America saw addiction as a frying egg in a hot pan but had no concept or corollary of what recovery was, how much of it was around them or how to expand it.

That era in the early 1990s was characterized by short treatment durations far below the minimum effective dose. Facilitated by a workforce who largely did not understand the culture of recovery managed by funding designed to provide as little care as it could get away with, which was easy to do because no one was advocating for it. People often could not get help, when they could get it, it was expensive, short term and failed to follow them into the communities in which they lived. The very notion of recovery science was foreign. Few people in recovery did so in the open, as we were living in a pathology-oriented model. People in recovery hid their status because they did not want to be associated with the carnage, particularly in that era when problematic drug use was seen as willful crime.



Here we are decades beyond those days, and yet we gauge measure effectiveness not by measuring recovery but by the avoidance of death by overdose, the antithesis of a recovery measure as part of the “opioid epidemic” which itself is myopic in focus. After finding our way, we fell for it once again. We shifted our attention from long term recovery and resiliency to the bare minimum threshold of stopping a death from one causation from one drug for one day. It seems like as a nation that our status quo ante in one of pathology and not resiliency. This is not to say we have failed to move things forward; we do see examples of holding out recovery and resiliency as being of worth. Yet, our systems largely stay focused on acute pathology-oriented measures. We see success as a reduction in the body count from overdoses and fail to measure our capacity to support long term healing. I wrote about this in [Overdoses in Decline - Progress on a One-Dimensional Measure](#). Of course we should want to reduce death, but we are capable of much more than mere existence. We should embrace that potential in how we measure and support long term healing.

It makes me wonder why as a country really are uncomfortable with recovery and resiliency. I pose that it is because drugs are part of our culture and our economy. We have [normalized drug use](#) in ways that we have not normalized recovery. Using drugs is our norm. Recovery and by extension not using drugs in our society remains an abnormal state. That needs to change.

Why are we so afraid of recovery as a nation? Bill White often used the word contempt in the context of societal perceptions of us. Our society at some level does not trust people who do not drink or use substances. Does society suspect that actually still use drugs and are lying? Do people feel self-conscious of their own use and project that judgement on to us? Is that contempt steeped in the moral model, the deeply rooted belief that we are deeply flawed people who did this to ourselves, that we are bad people, not like the rest of society and deserve only the bare minimum of support?

Will we ever get out of the clutches of the moral model that in essence view us through a lens as being as less than human? I suspect so, but we tend to take three steps forward and two back every decade or so, which makes the road we are on a long one. A road that generations before us journeyed but never saw the end of. They walked it anyway, as do we.

I recall a meeting I was involved in a decade ago with community members in the city where I live a few blocks from my home. It was in the era when the country started to become aware of increased incidence of death from overdoses. This was a phenomenon that itself took around a decade to reach a level in which society was bothered to even notice. That attention only occurred because overdose deaths started to impact white suburban and rural communities. Deaths had gone largely unnoticed and unaddressed over the decades prior to that when it was more confined to urban black and brown, urban Americans.

That meeting was largely attended by African American and Puerto Rican faith leaders, and there was a panel of local officials. As an addiction and recovery expert, I was invited to participate in the planned panel discussion. The audience was black and brown and the speakers in the front all white.

That black and brown community was one I had spent decades serving, so I knew something about what was occurring. As the meeting unfolded, I could feel the sense in the room, something I had seen with my own eyes from years working with the community that sat before us. We were telling them about a crisis that was not new to them at all, death and misery from addiction had been happening in their families and neighborhoods for a very long time. What was new was that it had become a crisis for the white community. There was a sense that perhaps that attention to deaths in the white middle class community just might translate to services and supports that would alleviate the suffering and loss in their community. I verbalized this truth by stating as much.

The room collectively exhaled as I spoke this truth. The reaction of those faith community leaders in that moment a decade ago was one of reserved hope that a focus on addressing overdose deaths and supporting recovery in America would now include Black and Brown Americans too. We can see now that the answer once again was no. We left them behind once again. Even in our myopic focus on a reduced body count from overdoses, the statistic that does not make the headline is that we still have a significantly higher rate of death from these causes in Black and Brown America. Even in our pathology measure we leave behind a large segment of our population, once again, as usual. The latest numbers show an overdose rate [one and a half times higher in African American communities in comparison to White communities](#). If we actually embraced a recovery orientation, it would necessitate including everyone in every community. Leave no one behind is a recovery value.

To move our institutions and our broader society to a recovery orientation, we need to calculate success beyond pathology measures such as the avoidance of death for one day or completion of a short episode of care. Below are ten questions for policymakers and thought leaders on advancing a Recovery Management–Oriented National Policy:

1. **Beyond Acute Care:** How can we shift from an acute-care model of addiction treatment to a recovery management model that authentically values our resiliency and provides sustained monitoring, support, and re-engagement over time for people with substance use conditions?
2. **Measuring Recovery Trajectories:** What resiliency indicators should be tracked to measure recovery trajectories over the long term, to better understand how to improve our transmission of recovery beyond just short-term treatment completion or abstinence at discharge?
3. **Longitudinal Accountability:** How can funding and evaluation systems be redesigned to hold our systems of care accountable for long-term recovery outcomes, rather than point in time, episodic “throughput”?
4. **Recovery Capital as a National Metric:** How can national health systems adopt recovery capital (personal, social, cultural, and community resources) as a core outcome measure, in ways that they are widely normed and uniformly operationalized?
5. **Continuity of Care:** What policies would ensure people have access to long-term recovery management supports—such as recovery coaching, mutual aid, digital recovery check-ins, housing support, and vocational pathways—across the life course? When will we ever understand that doing so would be less expensive and restorative to our society?
6. **Recovery Community Organizations (RCOs):** How can government agencies and funders better support the role of grassroots recovery community organizations in providing recovery management supports collaboratively with our formal treatment systems?

- 7. Integration with Health Systems:** What changes are needed to fully integrate recovery management into primary care, behavioral health, and criminal justice re-entry systems, so recovery supports are normalized and sustained in all of our institutions while maintaining their unique features?
- 8. Early Re-Intervention:** How can national systems embed early re-intervention protocols to prevent recurrence of substance use from becoming catastrophic events that we fail to identify and address until late in the latter stages, similar to how relapse is managed in chronic diseases like diabetes?
- 9. Financing Models:** What payment and reimbursement models (e.g., Medicaid waivers, bundled payments, recovery-linked performance measures) could sustainably fund recovery management supports beyond clinical treatment episodes so we can orient our systems on resiliency?
- 10. Cultural Transformation:** What public education strategies could help policymakers, providers, and communities understand addiction as a chronic, recoverable condition—and recovery management as the standard of care, not an optional add-on while they focus on acute pathological measures?

We let it happen once again; we have reverted to an acute pathology orientation and discarded a focus on long term recovery. The body count is not a recovery measure, it fails us in a myriad of ways in many ways, but perhaps primarily as not valuing our potential, which is nearly limitless. Focusing on what is wrong with us robs society of seeing our value and potential it robs our families, and it erodes our neighborhoods of what we have to offer. We are an asset to the communities we live in. This devaluation happens so often over the course of our long history to be much more than an anomaly. Our pathology orientation is status quo ante; recovery is this disruptive state. Let us work to shift our norms.

While I do not pretend to have all the answers, I am certain of this: any future recovery movement in the United States must flip the script and make recovery our norm, not pathology. To do so, we probably need to figure out what makes our nation so very uncomfortable with recovery.

Sources

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