

When Systems Become Isolated: The Erosion of Authentic Dialogue Across Our Addiction Care Institutions

There is a lot wrong with our SUD service system across our country currently when you scratch the surface to get underneath the press releases about how swell things are going. I was reminded of this recently when I read Rob Kent's essay in [Alcoholism & Drug Abuse Weekly Unstable Foundations](#). In it he referenced the erosion of treatment capacity in New York State and a survey by the InUnity Alliance, [Why New Yorkers are waiting months for mental health and substance use care?](#) The survey shows how



programs are struggling to stay open with challenges across a myriad of domains. From my conversations around the country, what is happening in New York state is happening in other areas as well. Most of these challenges occurring we have seen before, at least those of us around long enough to see cycles repeat. There is one particular facet of our care system in this era that differs from what we have experienced over the last fifty or so years. We lack the requisite feedback loops and open dialogue structures to ameliorate what is occurring that existed in previous times.

The challenges that echo those of prior eras center on the loss of focus on long term recovery and consequently, the viability of the field. It rests underneath a façade of all being well, maintained even as the infrastructure behind that curtain erodes. Access to care is being reduced. Belt tightening with funders is cutting care to the bone. Senior staff are abandoning the field. Programs can't sustain themselves, let alone help people get better. I hear of people getting very brief care if any at all and then being streeted quite literally with no place to go. Programs are reducing staff and shuttering their doors. Allocated funding is not getting out to the field. Openly discussing such things is perceived as unsafe by many people I have spoken to as to bring these issues out into the open is a threat to the façade of wellbeing.

These things have happened before. But when they did, groups would coalesce and meet face to face with government to change things. To force what was occurring to be officially acknowledged and course corrected. There was often contention and disagreement that occurred through these processes but ultimately all involved were better off persevering through the challenges. We have little of this left now as meetings are now held most often by zoom and most often to declare things rather than to explore collaborative solutions that could actually work. We are suffering a great deal as a result of the loss of these processes that would bring together federal, state and regional government across the nation with their stakeholder groups in meaningful dialogue.

Ironically, this is unfolding in the same period that recovery-oriented systems of care (ROSC) and stakeholder engagement became official policy goals. In many places, the rhetoric of collaboration increased while the frequency of genuine two-way interaction decreased. Treatment and recovery has increasingly become a prop for other agendas. The processes became more performative than community oriented and groups that acknowledge these things end up on the outside of the Potemkin village. There is then harm to people seeking help, groups trying to help them do so and the broader society. Government is charged with addressing in ways that support a healthy society, even as it increasingly loses touch with how to do so. The damage done behind is extensive as addiction drives costs in our society even as the impacted people remain overlooked.

This is what happens when collaborative processes erode and the only people left in the rooms in which policy decisions are made are ones who say yes to whatever those in charge already want to do. With horse blinders on, we carry on and shut out data and voices that conflict with the official positions held. It is a profoundly dangerous dynamic that is difficult to get out of, and probably impossible to do without painful epiphanies. Not unlike the process of recovery initiation itself. Pain faced is the only constructive way out.

This matters a great deal. Argyris and Schön (1996), in [Organizational Learning II](#) found that organizations often become trapped in defensive routines that prevent genuine examination of assumptions and the vital need to develop and sustain double-loop change processes. Double loop structures create space for questioning and fundamentally adjusting

a system's underlying assumptions, goals, and norms to the broader reality, rather than just tweaking rules to fix immediate errors. It requires moving beyond the processes of talking around problems without addressing them, protecting assumptions, and avoiding uncomfortable feedback that are the hallmarks of systems mired in pathology.

There is a significant disconnect between the work of helping people get better and how those efforts are viewed by the various systems that oversee it. Countless times I have sat in rooms over the decades where policymakers would present solutions and people with experiential knowledge on how things actually run would point out the fatal flaws of the plan. They would educate the leaders on all the unanticipated consequences or how the proposed top-down solution would not solve the problem and far too often make things worse. The discussions often got quite heated. People got really upset but they all continued to meet face to face and listen to each other. Through the process, real relationships with each other were formed and more often than not flawed policies were altered in beneficial ways. That rarely happens now in our technologically isolated, sound bite oriented world.

In the before times, everyone learned from each other. Relationships across the government and private sector gap were strengthened. This is particularly important in a field like ours that is deeply laden with stigma. Without feedback loops and relationships, the view becomes muddled. Unexamined bias reigns unchecked. The negative perceptions around addiction and the associated workforce then rule the process. We get drawn down to the worst outcomes because of the societal deep biases against who and what we are still underpin our society despite all the efforts to shift there perspectives.

Street Level Bureaucracy

That there is significant distortion in human service work is not a new phenomenon. Michael Lipsky a former professor of political science at MIT used the term [Street- Level Bureaucracy](#). It describes how public policy is actually implemented by frontline workers who interact directly with people. Workers on the ground in the real world, counselors, social workers, teachers, police officers, probation officers, and healthcare providers must exercise considerable discretion in their daily decisions, effectively shaping how government policies unfold in real practice. He argued that because street-level bureaucrats operate under conditions of limited resources, high caseloads, competing demands, and ambiguous policy goals, they develop informal practices and coping mechanisms to manage their work effectively.

We also have a gaping wide data implementation gap. Those at the helm far too have little sense of what is actually occurring on the ground. They rely on reports which differ greatly from what is unfolding in the trenches. It is a chasm that grew bigger during the COVID Pandemic as virtual spaces became the norm and physical meetings ended. The Pandemic isolation is over but physical meetings never resumed. Policy makers far too often spend zero time with the people doing the work beyond press conference style events. We are losing the capacity for connection across the technologies of isolation. What does it say about our society when the very systems that are designed to connect people to healing are themselves detached and isolated from each other? They become system destined to fail. The solution must include policy people spending more time on the ground. To do so would require intentionality and it would be very uncomfortable. The longer it is delayed, the more painful it will be, not unlike the very process of recovery initiation itself.

As a result, what occurs is often not the policy written in laws, regulations, or strategic plans, but those things as interpreted and applied by frontline staff trying to actually get things done. This is why feedback from street-level workers is essential for effective governance. When policymakers become disconnected from frontline workers, they can lose sight of how things really function in practice, leading to unintended negative consequences. Frontline personnel often recognize emerging problems long before they appear in administrative data. If systems lose the forums, advisory councils, provider associations, and informal relationships through which this critical knowledge once flowed, policymakers then come to rely primarily on flawed performance metrics and reports that fail to capture what is happening on the ground. The proverbial plane flying through clouds towards a mountain range with a faulty altimeter. It is why one of my dreams would be to run those who operate these systems and govern the work through a simulation of a typical referral and admission to care process replete with the long delays, repetitive and deeply intrusive questions and shame inducing moments that can be soul crushing those we push through these systems, but I digress.

From Relational Governance to Contract Governance

Over the decades we have replaced systems built on relationships with ones built on contracts and metrics collected behind closed doors and rarely shared. Most often metrics that fail to capture what people actually need to initiate and sustain recovery. As an example. one system I worked in had a major funder who would count it against providers if a

person with an addiction returned to treatment within ninety days. Providers end up being punished because the systems fail to understand the underlying dynamics and metrics are weaponized even as the data fails to capture what is really occurring. The rationale was that this indicated the treatment did not work, even if the treatment itself was a shorter duration or lower intensity than the person actually needed, an all-too-common occurrence. It is possible that the person received poor treatment, but there are dozens of other reasons that could occur when a person is grappling with recovery initiation. It is quite possible that a rapid return to treatment means a person has developed a critical insight into what is not working and where they need more help. Or the care rationed out was not enough for them to sustain recovery. They knew enough to return for more help, which is a substantial victory for that person.

As systems run in parallel, the loss of focus on relational facets and the use of metrics (far too often the wrong ones) to measure efficacy has led to profound problems. Metrics are vital, but we have a long way to go to get to the right ones. There is a great deal of nuance in communities served that will perhaps never allow us to remove human centered facets from our work. We need to have systems that operate relationally for us to sustain effective care in our field. Increasingly all of that is missing. We are in a dysfunctional dynamic not unlike what occurs in families that are mired in addiction where there is significant investment in sustaining the underlying pathology and a tacit agreement to never talk about it. What irony.

The decline of Intermediary Institutions.

From the 1970s through the early 2000s, there were more robust government advisory councils, regional provider associations, local and regional associations, regular cross-sector planning meetings and a high degree of informal relationships between government agency staff and field leaders. Many of these structures either disappeared, became compliance-focused, or lost influence as systems shifted toward managed care, performance contracting, centralized procurement, and large administrative data systems that are not publicly available or subject to meaningful input.

Years ago I attended a lecture by Robert Putnam and subsequently read his book, Bowling Alone: The Collapse and Revival of American Community (Putnam, 2000). It was quite influential on my way of thinking. Putnam helped move the science of social capital into the public space, which as an aside, was instrumental to the conceptual development of recovery capital. A quarter century ago he was documenting the loss of social institutions and its consequence in our society. He also accurately predicted that failure to revive social institutions would lead to a less functional more divided American society. We can see the evidence of what he wrote about all around us. We have fewer professional associations, local coalitions, advisory councils, regional planning bodies, and stakeholder networks that function to create feedback loops between policymakers and practitioners. Government and institutions fail because they lose the ability to see relationships, patterns, and heed feedback loops (Senge, 1990). Other books Putnam wrote suggest that solutions focus on rebuilding relational systems and authentic community.

I have written about this before in the [Loss of Institutional Knowledge—a Critical Tipping Point in the SUD Workforce Crisis](#). The disappearance of longstanding government-field relationships is fundamentally a loss of institutional memory. When experienced people retire or are excluded from decision-making processes, the system loses its ability to recognize recurring patterns and avoid repeating mistakes. In [Constricted Ways of Knowing and the Loss of Recovery as a Focus of Our Institutions](#) I wrote about how the short-term focus on reducing death in one way from one drug is exacerbating the loss of focus on long term recovery. These are related to the challenges articulated here.

I am a long-term optimist. What we are doing now is not working in respect to helping people obtain and sustain long term recovery. People are suffering in ways that cannot long be ignored. Our systems of care are not providing what individuals; families and recovery community members need from them. It has happened before. This will inevitably result in a groundswell call for change and history tell us that change can and does occur and is most often a result of these factors. 1) a care system that fails to focus on recovery leading to a 2) grassroots call for change met by 3) enlightened leaders wanting to do better and meaningfully include members of the community in policy design, implementation and evaluation. History shows us that these three elements occur together from time to time. Most often when the first two make the challenge visible that the third falls into place.

What happened next?

What unfolds next depends on both how our systems respond and how grassroots groups respond. We either will begin to address things as they are or kick it down the road a bit. One of the paradoxes that can occur when things are not working well is to sustain the underlying assumptions and use data to affirm the internal biases and remain on the same path. In the short term, it is nearly always a less painful alternative even as it is anguishing the longer we avoid change. It

is what occurs when relational dynamics break down and they lose double loop change capacity. People and institutions alike can believe the wrong things more fervently because letting go of the deeply held assumptions can be painful and difficult to do when so much has been invested in the current infrastructure. Subsequently, our infrastructure fails to deliver long-term recovery outcomes. The longer we do that, the more damage that will be done and the more difficult the change process. Again, not unlike the process of recovery initiation.

Questions to consider:

- Can we deliver long term recovery in systems that primarily focus on sustaining a heartbeat and acute stabilization?
- What are we measuring and are these measures the right ones? How accessible is data? How do systems of care verify with the impacted community they are capturing the right information?
- How do our systems of care and governmental institutions respond to constructive criticism? Is there intentional room for it or is it rejected and groups who raise issues get banished from the processes?
- Where is there room for candid face to face open dialogue?
- Are system leaders exposed to diverse perspectives or are they isolated in a monoculture of thought?
- What are the sacred cows of our era that no one can challenge?

The culture of addiction is a flawed belief system. Moving people out of the culture of addiction into a culture of recovery expose people to very different ways of being. If our systems are closed to different ways of seeing things, how can we expect to model it for those in our care?

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