

**In Praise of Service:  
A Call for Self-Inventory  
and Self-Renewal In the 1990s \***

**A Lighthouse Institute Monograph**

William L. White, M.A.  
Lighthouse Institute  
Bloomington, Illinois

\* An elaboration of keynote addresses presented at:

1. The 37th Summer Midwest Institute on Alcohol and Drug Abuse Training, July 14-19, 1991, Decatur, Illinois. Sponsored by: Illinois Department of Alcoholism and Substance Abuse, Indiana Department of Mental Health, Michigan Office of Substance Abuse Services and the Wisconsin Department of Health and Human Services.
2. The IADDA Fall Conference, November 20, 1991, Springfield, Illinois. Illinois Alcoholism and Drug Dependence Association.

**Published by the Lighthouse Institute**

**Bloomington, Illinois**

**© 1993 William L. White**

**All Rights Reserved. No part of this publication may be reproduced in any form or by any means without permission in writing from the author.**

**Additional copies of this publication may be obtained by sending \$ 5.95 plus \$ 2.00 shipping and handling to:**

**Lighthouse Institute Publishing**

**702 West Chestnut Street**

**Bloomington, Illinois 61701**

**(309) 827-6026**

**Other books by William White available from the Institute include:**

**The Call to Write: An Invitation for Aspiring Writers (with Pamela Woll) (1995)**

**Incest in the Organizational Family: The Ecology of Burnout in Closed Systems (1986)**

**Critical Incidents: Ethical Issues in Substance Abuse Prevention & Treatment (1993)**

**The Culture of Addiction, The Culture of Recovery (1990)**

**The Training Life: Living and Learning in the Substance Abuse Field (with Bruce Joleaud, Felicia Dudek and Bob Carty) (1994)**

**In Praise of Public Service:  
A Call for Self-Inventory and Self-Renewal in the 1990s**

William L. White

*I. Introduction*

It is a pleasure and an honor for me to be here today. Through my training, research and consulting activities I have the privilege of being able to talk to substance abuse prevention and treatment professionals from all over Illinois and around the country—to hear of their concerns about where we are as a field and where we are going. What I hope to do in the next hour is to articulate concerns that are being expressed within the field with increasing frequency and intensity. I want to use my voice to pass on concerns of persons who would not likely be afforded, nor who would want, the visibility of this podium.

The voices I hear within the field depict a field at a critical turning point. They depict a field in crisis—facing threats that could fundamentally alter the character of the field. While the crisis is being described in most quarters as a financial crisis, more and more persons I hear are depicting this crucial period as a spiritual crisis—a crisis in values. While the field is speaking of this crisis in terms of restrictive third party coverage, HMOs, managed care, Medicaid cuts and so forth, I will describe this crisis using terms like mission, vision, values, ethics, and commitment. I will suggest that the centerpiece of this crisis is the changing value attached to service within our culture and within our field of professional endeavor.

The crisis I am speaking of has emerged out of two decades of unprecedented success within our field, and what a period of success it has been. Who could imagine the current status of our field when only a few short years ago alcoholics and addicts were institutionalized, lobotomized, electroshocked, hydrotherapied, drugged beyond coherence and consciousness, restrained and secluded—all in the name of humane intervention? Who could imagine our status today when only a few short years ago there was no community-based system of substance abuse prevention and treatment services? It was so recent—before we decriminalized public intoxication—that alcoholics were routinely banished into drunk tanks where many died of acute illnesses or were found hanging in their cells. Who could have predicted that hospitals that twenty years ago wouldn't admit alcoholics and addicts for acute medical care would open and aggressively

market new chemical dependency units? From the days when only late stage addicts saw the light of treatment, who could have predicted that we would have EAP and SAP and family intervention technologies and heightened public awareness that would bring whole new generations of clients to treatment before they had lost everything? Who could have predicted that we would have president's wives and every other manner of celebrated figure on television speaking openly about their addiction, treatment, and on-going recovery? Who could have predicted that communities that boasted five AA meetings per week 20 years ago could now list a hundred such meetings along with uncountable adaptations of the 12 step program for problems other than alcoholism? Who could have predicted such an aggressive campaign to stigmatize and criminalize drinking and driving in this country? Who could have predicted the long-coming breakthrough perception of nicotine as an addictive and lethal drug? Who could have predicted areas of the country in which people would openly confess their alcoholism and recovery—it would be a fad in some places—while shamefully hiding their smoking? Who could have predicted that we would begin to focus on the special needs of women and people of color and persons with concurrent physical or psychiatric disabilities as an essential element of our mission? Who could have predicted the force and spread of the COA movement? Who could have predicted that our sustained prevention efforts would see a decrease in the number of illicit drug consumers and smokers in the United States? Who could have predicted that we would bring doctors, nurses, psychologists, social workers and scientists and others back into what is now a legitimate component of our health care system? We've come so far! What crisis could threaten such unparalleled progress?

It is paradoxical that this very same success fertilized the ground from which our current crisis springs. The crisis has emerged out of the excesses of our explosive growth and our industrialization. The signs of this crisis can be seen in many quarters.

- Occupancy rates in private and hospital-based chemical dependency units have dropped precipitously in many areas, while waiting lists in public sector programs treating clients less financially blessed are unconscionably long.
- After the explosive proliferation of new substance abuse programs, private sector programs are being closed, reorganized, or merged in unprecedented numbers.
- Morale of staff within the field has eroded over the past decade, contributing to excessively high rates of staff turnover for direct service workers. A recent study of

the region of Illinois this conference is being hosted in revealed a 40% annual turnover of substance abuse counselors.

- There is a new form of staff turnover—older, historically committed workers with significant tenure in the field are leaving professional roles. When interviewed they speak of something being lost in the field. Some paradoxically say they are leaving to try to recapture the original spirit of service that brought them into the field.
- There is a crisis of public confidence in our field. Exposés of financial exploitation and other client abuses have led the citizens of our communities to look at us with a more suspicious eye. Talk of "treatment ripoffs" among active alcoholics and addicts adds one more obstacle to entry into treatment and degrades our image in the minds of our most important constituents.
- There is a growing feeling among workers that the identity and character of our field is being shaped externally rather than internally—that we are not in control of our own fate.

Today we will explore the roots and nature of this crisis and create both a vision of where we need to go and an agenda that can help us use this crisis to revitalize our field.

## ***II. A Cultural Context***

There is a broader cultural context to the current crisis within the substance abuse field. Commentators from many disciplines have called our attention to fundamental changes occurring in social structures within the United States. Changes in nuclear family structure, decreased contact with extended families, the loss of neighborhood, and the strain on community institutions—our churches, our schools, our workplaces—all bear testament to the dissipation of the social glue that has bound us to one another. Out of these weakening social structures has come a decreased clarity of values and a decreased capability to transmit values. Most noteworthy among these value shifts is the movement away from social duty and obligation—a belief in the nobility of sacrifice for something beyond the self—to a celebration of self-interest, self-exploration, self-indulgence. The "WE-ness" of our culture has disintegrated over two decades into "I-ness." This trend has been well documented beginning with Christopher Lasch's *The Culture of Narcissism* in 1979 and culminating in the publication of Robert Bellah and

associates' wonderfully illuminating study, *Habits of the Heart*. Both of these books document this shift in values and the resulting loss of connectedness and loss of community. The emergence of greed and materialism has been portrayed on the screen in movies such as *Wallstreet* and in works of fiction such as Tom Wolfe's *Bonfire of the Vanities* and in real life headlines of insider trading scandals, the savings and loan disaster, and the fall from grace of a wide assortment of business, political and religious figures.

Tom Wolfe tells a particularly poignant story that illustrates this transformation in values. Wolfe was walking through the streets of New York doing background research for his book and observed some young men walking towards him, each wearing a peace symbol around his neck. Wolfe was positively struck by this sight of young men who in the late 1980s who were visibly exhibiting political consciousness and concern about war and peace. As the young men got closer, Wolfe realized these youthful icons were not peace symbols, but the hood ornaments from Mercedes-Benz' worn on thick gold chains. The Mercedes-Benz hood ornament hanging on a gold chain we could take as the symbolic backdrop to introduce the more detailed exploration of the spiritual crisis within the substance abuse field.

No Professional discipline is immune from such overwhelming social currents. These social currents set the context for our discussion today. To bridge the gap between culture and professional discipline, I would like to tell a story that I have overheard with overwhelming repetition the past two years within the substance abuse lecture circuit. I'm going to tell it for the one or two of you who may have missed it. As an amateur anthropologist, I believe you can tell a lot about a professional field by listening to the nature of its storytelling. See what you think this story tells us about ourselves.

There were two neophyte hunters who went to the north country to hunt bear. Neither of them had hunted anything before, let alone bear, but typifying the grandiosity of the eighties, each had the latest and most expensive weapons of destruction and were confident of their triumph over the beasts. On the afternoon of the second day, they were becoming quite tired from a prolonged trek up a mountain trail. Rounding a sharp bend, the two hunters suddenly found themselves staring into the face of a bear whose prodigious size, close proximity and sudden ill-temper so startled them that they dropped their guns and began tearing down the mountain trail for their very lives.

Their terror was intensified by the sounds of enraged bellowing and breaking branches coming from behind them. Suddenly as if inspired one of the hunters threw himself on the ground, tore off his boots, reached frantically into his back pack and began tying on his tennis shoes. His standing partner screamed at him in disbelief: "Those shoes aren't going to help you outrun the bear!" Jumping from the ground into a full sprint, the tennis-shoed hunter shouted back, "I don't have to outrun the bear; I just have to outrun you!"

Does anyone wonder why this story has suddenly become so popular within our field? Many of us in this field have felt the breath of the bear and have reached for our tennis shoes during the last decade.

### ***III. The Elements of Crisis***

There are at least five elements that make up the building blocks of the current crisis of values of which I speak today.

#### **A. Rapid and Turbulent Change**

The first of these elements involves the experience of rapid and turbulent change within the substance abuse field. That change—most notably our explosive growth over the past two decades—as noted earlier, has come from our success. The field was not prepared for the sheer speed and scope of this growth. We historically brought new people into the field through a guild system wherein newcomers served informal apprenticeships under the sage guidance of experienced mentors. The speed of our growth outstripped our capacity to mentor—to transmit history, traditions, and values. Our values were further diluted by excessively high staff turnover through which we regularly bled out accumulated knowledge and experience. Noting this transience and lack of continuity of personnel, workers say to me: "How can we expect clients to bond to an environment to which we can't even hold paid staff?" As we have grown larger, the culture within the field has weakened. We are a field in motion whose working constituents are calling for us to stop and define who we are and where we are going.

#### **B. Competition and Isolation**

The second element that set the stage for our crisis in values was the competition that emerged from the proliferation and oversaturation of service providers in many areas.

The first effect of this sustained competition and struggle for survival has been a growing concern about breaches of ethical conduct related to business and clinical practices within the field. Such concerns include aggressive client recruitment processes, the overdiagnosis of chemical dependency (particularly with adolescents), fraudulent business practices and unethical marketing practices. Ethical concerns about how CD services are marketed, for example, include:

- misrepresentation of the scope and intensity of program services,
- superficial specialization—the announcement of a new cocaine treatment track that upon close examination is a new movie and an exercise bike,
- exaggerated claims of success (Inebriate asylums of the late 1800s often boasted cure rates exceeding 90%; if clients left and never came back, they were assumed cured—no news was good news. Some claims of success rates today may be using technology only a notch or two above that of these early predecessors.),
- television and radio adds that unduly exploit the pain and guilt of family members, and
- the exploitive use of clients in the marketing of program services.

Are we on the verge of blue light specials, two for one sales, rebates or seasonal discounts? Adds for chemical dependency treatment that reflect such aggressiveness and poor taste damage the credibility and integrity of the profession.

A second effect of competition has been increased isolation of organizations within the field. Programs became increasingly isolated as competition replaced cooperation between agencies and as the responsibility for relationship-building with local communities was turned over to marketing professionals. When I wrote many years ago about the increasing prevalence of incestuously closed organizations within the substance abuse field, I made the following observation.



We barricade ourselves within professional and social communes isolated from the outside world and boldly challenge our clients to reenter the life of communities from which we have long ago lost touch.

This propensity for closure and isolation has intensified in the years since those words were first written. We have fragmented and isolated the whole field of human services into specialties—organizing each agency around an individual disorder or symptom—on the assumption that clients would cooperate and have only one problem at a time. Such fragmentation has left us woefully ill-prepared for the growing number of clients who present with multiple problems and a host of environmental obstacles complicating their entrance into stable recovery.

### **C. Preoccupation with Profit and Regulatory Compliance**

The third building block of our current crisis is a fifteen year obsession with profit and regulatory compliance.

The folk wisdom of the decade tells us that we must become like businesses. It tells us to import the planning, marketing, fiscal, management, and public relations technology from private industry. It tells us we have to make a profit even if we are not-for-profit organizations. That is the folk wisdom and all the soothsayers say that's what we have to do to survive.

While this wisdom has enhanced the development of more administratively and financially viable organizations, there is danger in this new orientation when the pendulum swings too far. The unspoken danger in this wisdom is the possibility that we could survive while losing our soul. Many organizations are being diverted from their historical mission while chasing this new business panacea. We need to redefine success, not in terms of bigger budgets and bigger buildings, but in terms of better service. If we are to compete, then let's talk in terms of recovery rates rather than occupancy rates. In retrospect, we may discover that many of the programs that had the power to make money in the 1980s did not have the power to change lives. Money has no utility within our field unless it is converted into resources that can change lives. Money must be the servant of our mission, not the mission itself.

Chasing the gods of growth and profit have been buttressed through our worship of regulatory compliance. External regulators define who we are, what we do, when we do it, under what circumstances, to whom, for how long, and at what cost. Many of our programs are chameleons whose color changes hour by hour depending on which regulatory site visit is occurring. This obsession with regulatory compliance weakens our fundamental character and induces passivity. It programs us to think of the regulators as the ultimate arbiter of quality services rather than the people who receive those services. It turns us from people changers into people processors. Treatment is measured not in terms of effects on the lives of our consumers, but in our ability to process them efficiently. We hire people with the skills and passion to help change lives and then drown them in paper and procedures. Progress becomes defined as a completed progress note—appropriately dated and signed with the right color ink—not progress reflected in the transformation of a client's life.

We have all been caught up in this process. As a program director in the 1980s there were many days as one survey team left and the next one arrived that I thought, "I could have a wonderful program here if I could just get rid of these clients." There were days I was tempted to get rid of those wild, free spirited counselors and hire a team of technical writers. Accreditation and program licensure should be seen as a baseline achievement, not the ultimate source of a program's character and identity. This baseline merely says that you have a body that has all the essential parts, but no accrediting or licensing agency can breathe life and power into that body.

The glorification of profit and regulatory compliance have created beautiful edifices devoid of substance. There are programs whose facilities are beautiful, whose program manuals are publishable, whose clinical records are unimpeachable, whose daily activities run like a well-oiled machine, but who do not have the power to incite and support the movement from addiction to recovery. Such programs have no passion, no commitment, no soul. Their commitment is not to a population of clients or to a professional field of service. Their commitment is to money—they have passion about addiction only to the extent that it exists as a billable diagnosis. To that goal—money—they have attained the highest evolution of efficiency as a people-processing institution. Clients aren't "in treatment" at these sites; clients "do treatment" like cons "do time." Professional helpers at these sites are turned into robo-counselors—super efficient processors. In such an organizational climate, clients and staff can

do treatment in a manner that does not require commitment or change from either. Prevention programs have not been immune from such influences. Prevention programs can get caught up in processing activities, rather than people, with a similar disregard for the effect of such effort.

As the period of highest profitability and popularity of the substance abuse field wanes, those institutional predators with veneer-thin commitment to our field will flee in great numbers. This is not, however, a simple story of good guys and bad guys. Even some of the best programs have felt themselves pulled into this people and activity processing mentality. Some of our best programs today have staff who report that in recent years something important has been lost in the life of the program. What is in jeopardy of being lost is the very heart and soul of the program: the passion and commitment to service.

#### **D. Overextension of Technology**

The fourth building block of our current crisis grew out of the over-extension of our prevention and treatment technology. We have developed over the last half century some wonderful assessment and treatment technology. There are hundreds of thousands of people in active recovery as a result of that technology. The problem is that our assessment and treatment technology is based almost exclusively on clients with very homogenous characteristics: white, middle and upper class males in their forties and fifties in late stages of gamma species alcoholism who present with minimal concurrent psychiatric impairment and who have minimal environmental obstacles to their recovery. Like compatibility between computer hardware and software, our assessment and treatment software works exceptionally well when applied to the client hardware for which it was developed. The problem comes when we interact this treatment software with clients with fundamentally different hardware. The result is often a shame-based treatment system. We place clients in treatment regimes that have little likelihood of success and then when they fail to respond to such treatment we blame them. We say: "You have to go back through the same 28 day program because you didn't do it right the last time."

The problem is not just that the treatment is unsuccessful. When we mismatch client hardware and treatment software, the client not only leaves treatment with their original problems intact but may have acquired additional problems as a direct consequence of the treatment experiences.

We call such consequences iatrogenic illnesses—they are treatment caused. Clients not responding to mainstream treatment often leave not only with their addiction intact but now have the added experience of treatment failure. Treatment failure may reduce the likelihood of future recovery through its enhancement of passivity, learned helplessness, learned hopelessness and dependence. Serious questions of financial exploitation and iatrogenic effects of treatment must be raised by the continual placement of relapsing clients in treatment modalities that have historically failed to provide a medium for movement into recovery.

In this period of explosive expansion of programs, we have over-extended our technology way beyond the populations for whom it was developed. There are special concerns about the iatrogenic effects of this misapplication to adolescents, the aging, women, people of color, persons with physical or psychiatric disabilities, and persons with enormous environmental obstacles to recovery, e.g., the homeless. Traditional treatment technology must be applied to new populations with great tentativeness and gentleness—not with the aggressive arrogance that has characterized our approaches to treatment by recipe. To the treatment fundamentalist who would rejoin that many adolescents, women, people of color, etc. have gotten sober through traditional treatment, I would suggest that many of these clients got well in spite of rather than because of our treatment technology.

We must disenthral ourselves from narrowly prescribed treatment philosophies and techniques that have been elevated to the status of religious dogma and ritual. As we move into the nineties we must do two things. We must write prevention and treatment software that fits the needs and characteristics of subpopulations within an increasingly diverse culture. We must then institutionalize these new technologies by transferring them out of pilot and demonstration sites into the mainstream of substance abuse prevention and treatment. It's not enough that more than one thousand women in Illinois have been involved in the fourteen Project SAFE sites since 1986. The issue is how do we take the new knowledge acquired through Project SAFE and mainstream it so that women entering any substance abuse treatment program in Illinois will be benefitted by that new knowledge and technology.

We need new paradigms that don't destroy our older paradigms but embrace and extend them. The new paradigms must be broad enough to embrace multiple patterns of abuse and addiction which spring from multiple etiological pathways and which unfold in diverse familial and

cultural environments. The new paradigms must supplement our traditional rehabilitation technology with habilitation technology. The new paradigms in like manner must be able to envision, legitimize, and facilitate multiple pathways of long term recovery.

### **E. Service and Sacrifice as Pathology**

The final building block in this crisis of values within our field involves changing judgements about the role of service within the field. This has involved two related processes: narcissistic inversion and the pathologization of commitment to service.

Working within human service disciplines has always been a medium through which persons could seek self-exploration and self-understanding. There is nothing inherently wrong with this practice, particularly when such benefits do not interfere with the quality of service to others. There can be an inversion process, however, whereby knowledge and skills intended to move outward to serve clients gets turned inward through an intense preoccupation with the personal and interpersonal problems of staff. Fueled by the narcissistic preoccupations of the whole culture in the most recent decades, this inversion process within human services has intensified resulting in a growing number of persons who use the field to receive rather than provide therapy. These narcissistic preoccupations have weakened the commitment to service.

Where narcissistic inversion would weaken commitment to service, the overextension of the concept of codependency would begin to define commitment to service as pathological. I am speaking of an era in which one's very choice of a helping profession was framed as pathology rather than virtue—was defined as a symptom subsumed under the newly created and ever-broadening disease of codependency. I am speaking of an era in which simple acts of courtesy and kindness to clients or to each other were met with the cryptic remark from another staff member: "How codependent of you!" Passionate commitment to service was something to hide, something to indicate one's untreated family of origin issues, something to be seen as the worst rather than the best within us. Staff who arrived in the field with great passion and ardor were suddenly confronted with a professional milieu in which such work-related fervor was stigmatized. Suddenly everything was pathology; everyone was pathological. A cartoon in one of our journals vividly illustrated this stance. The cartoon shows a huge auditorium with the banner "First Annual Convention of Adult Survivors of Normal Parents" and in this gigantic

auditorium sits one geeky-looking character in the front row. In an environment where one's own issues must be explored so relentlessly, service to clients becomes a troublesome and tiresome diversion from the primary mission of self-exploration.

If there is a challenge for our culture and our field in the 1990s, it is the rediscovery of the nobility of service to others. It is the rekindling of the kind of service and sacrifice that springs not from masochism or self-hatred but from the recognition of our connectedness to each other and from the recognition that the self is enriched through acts of service.

Many social commentators have suggested that individuals and countries should choose their enemies carefully because they are destined to become like them. Professional disciplines reflect this same process. Crime fighters are at high risk to commit crimes in the name of law and justice. In our own case, in fighting addiction, we have in the 1980s taken on dimensions of character that are the essence of addiction: narcissistic, grandiose, aggressive, rigid, exploitive, excessive, manipulative, and deceitful. Like the addict in crisis, it is time for self-inventory and self-renewal.

These five themes—rapid and turbulent change, competition and isolation, obsession with profit and regulatory compliance, technology over-extension, and the relabeling of commitment to service as pathology—are the seeds from which grew the current crisis of values within the substance abuse field.

#### ***IV. Strategies for Self-renewal***

What is emerging out of this crisis is a period of self-inventory and self-renewal that is likely to extend through the 1990s. The 1990s within our culture and within our field are likely to parallel many aspects of the 1960s. There will be a serious and at times somewhat painful reevaluation of values and commitments.

Many programs of excellence have already begun this self-assessment and self-renewal process. They are charting the way for the rest of us. The directions which they point for our field—and

for our culture—involve a recrystallization of values and a recommitment to service. Six strategies seem to be emerging as vehicles to personally and collectively recenter ourselves.

### **A. Self-Inventory**

The first strategy for self-renewal involves a process of self-inventory—a process whereby we step back from the image of ourselves projected in our press releases and conduct a sober inventory of our character strengths and deficits. The purpose of this strategy is to step back from the franticness and flurry of day-to-day service delivery to review where we are at as an organization and to determine if it is where we want to be, where we should be. It is to assess where we may have veered off course from our historical mission. The goal is not to shame the recent past. It is to see where we are at as an organization as part of a developmental process and to take control of the future direction of that development. Programs of excellence are conducting this inventory without blame or scapegoating, recognizing that progress is marked by an ebb and flow in which it is often hard to separate opportunity from diversion.

Programs of excellence are utilizing a variety of methods to conduct this self-inventory including informal discussions in staff meetings, formal planning meetings, board-staff retreats, internal staff surveys, client/community service satisfaction surveys, and assessments and interventions conducted by organizational development specialists. These approaches focus on listening to each program's individual and organizational clients as well as listening to the staff charged with serving those clients. Whether self-inventory is launched as a proactive process or in response to serious organizational problem, it is the beginning of self-renewal.

### **B. Organizational Renewal**

The second renewal strategy being utilized by programs of excellence involves rebuilding the internal strength of the organization. If there is any message that collectively springs from the voices of front line workers it is the following: "We don't need bigger organizations, we need healthier organizations! We need organizational cultures that are congruent with the values of recovery." During the growth spree of the past decade the sheer pace of change often made it impossible to build in essential elements of healthy organizational structure and process. The self-inventory process quickly reveals such areas of neglect. Many programs of excellence are

taking the stance—or are being forced to by funding cutbacks—that the goal for the immediate future is no growth, that the focus must be on enhancing quality of existing programs before new services are initiated. A particular focus of organizational renewal is the enhancement of team performance through relationship-building across organizational units and increasing the scope and intensity of staff supports, such as clinical supervision and access to training. Conditions like role overload, role conflict, role ambiguity, role-person mismatch and other role stressors that emerged during the period of rapid change are diagnosed and reduced to the extent possible. Such developmental problems will not always be solved quickly but the crucial step is their identification as high priority agenda items to which staff time and emotional effort will be expended.

Programs of excellence are also exploring and celebrating what Tom Peters has referred to as "bureaucracy bashing." They are flattening organizational structures and decentralizing power and decision-making. They are culling out and joyously destroying artifacts of policy, procedure, structure, roles and, most importantly, forms and paper that no longer support their primary service mission. They are simplifying and streamlining and integrating and, in short, flushing the bureaucratic fat out of the institutional arteries.

### **C. Vision, Values and Ethics**

The third renewal strategy being used by programs of excellence involves the development of a shared vision, shared values and an ethical foundation from which to redefine and re-energize the focus on service. Through exercises in strategic planning, on-going discussions about mission and philosophy, or efforts to develop codes of ethics and codes of professional practice, programs of excellence are struggling to wrest control back that has been abdicated to external forces and redefine their mission and their character. Programs of excellence, by recentering themselves, are using the technology of business to support their mission rather than letting business become their mission. They are doing this by filtering decisions related to the business of the organization through the newly focused values and mission of the organization.

This assertion of the importance of mission and values harks back to a parallel period in the historical evolution of Alcoholics Anonymous. AA went through a turbulent period in the 1940s shaping the traditions that would govern the group life of the fellowship. The need for such focusing came about as a result of explosive growth and visibility, in short, from AA's success.



What came out of this internal soul-searching within AA was an understanding that would profoundly influence what became the 12 traditions. That understanding was a recognition that money, power, politics and property separately and collectively had the potential to divert AA from its single mission—carrying the message of recovery to the still suffering alcoholic. Fifty years later, programs of excellence are learning the same lesson. Like AA in the forties, programs of excellence are crystallizing the values that will govern their group life and guide their delivery of substance abuse prevention and treatment services.

A growing number of programs of excellence are also attempting to cultivate spirituality as a source of organizational renewal and empowerment. To speak of spirituality in an organizational context does not rely on the religious or the mystical. It simply says that there are resources and relationships outside the organization that can empower and imbue hope. It simply says that a commitment to service brings duties and responsibilities that transcend individual and institutional self-interest. Spirituality as an organizational concept recognizes our essential connectedness to one another and that this connectedness can be experienced through acts of service. Spirituality as an organizational concept recognizes that the great issues of our day are played out in microcosm in our daily lives, and that it is through our individual and collective actions—reaching out beyond our self-interest to discover mutual interests—that we change the world. Spirituality is igniting and nurturing hope within the organization and the transmission of that message of hope into the world.

#### **D. Commitment: The Rediscovery of Professional Passion**

The fourth renewal strategy being used by programs of excellence involves re-igniting passion, enthusiasm, and commitment to this vision of service. Programs of excellence recognize the critical role staff energy and emotion play in the process of client empowerment. Deeply imbedded, self-defeating patterns of passivity, helplessness, hopelessness and dependence in the lives of our clients can't be challenged by staff who are emotionally uninvolved or convey feelings of futility, boredom, frustration, or hostility to their clients. Programs of excellence are recognizing that change is something many clients will get caught up in rather than consciously choose—more a serendipitous adventure that they wandered into rather than a premeditated course of action. Such programs recognize that it is our passion and energy that must ignite the earliest stages of the change process. Our energy is the battery that can be used

to jump start other people's lives. It is the passion of our involvement that allows us to perform this kind of psychological resuscitation. In the face of client hopelessness, it is our hope that must open up new possibilities. In the face of helplessness and passivity, it is our faith and energy that will empower the client's will to act.

Programs of excellence are casting off the mantle of pathology attached to service and once again celebrating the nobility of what we do. Programs of excellence are re-elevating persons to the status of organizational heroes and heroines who view service in terms of privilege rather than pathology, who don't see personal happiness and fulfillment incompatible with social duty and public service. Programs of excellence are building in affirmations and rituals to nurture personal and institutional commitments and to explore the actions that embody such commitments.

Programs of excellence are re-asserting that their commitment is to the service of people, not to particular ideas or paradigms. The commitment is to assess and respond to the needs of their clients and their communities with all of the resources they can command. This commitment means that the needs of their constituents define the models of service, not vice versa.

Many programs of excellence are also reaffirming that this commitment to service must embrace the disempowered. It must embrace clients of different sexes and sexual preferences. It must encompass all ages and cross generations. It must embrace people of color and communities of color. It must embrace addicts within the criminal justice system. It must embrace addicts who have significant and special obstacles to recovery whether the obstacle is HIV, psychiatric illness or homelessness. It must embrace the full spectrum of alcoholics and addicts, including those without power and influence (and insurance). The commitment must be inclusive rather than exclusive.

#### **E. Community Building and Consensus Building**

The fifth renewal strategy being utilized by programs of excellence involves rebuilding relationships with other agencies and individuals in the professional community and rebuilding relationships with community institutions. The purpose of this reaching out is not public relations or marketing, but listening and relationship-building. It is an attempt to rejuvenate our

own organizations through the injection of new ideas and perspectives. It is a genuine attempt to seek out the needs and resources within a community. It is an attempt to reach other persons with shared concerns. It is an attempt to link our own vision with that of kindred spirits. It is an attempt to link resources to increase our power to effect positive change in individuals and in the environments they inhabit.

Programs of excellence are recognizing that we must stop building walls and begin building bridges to link us with other health and human service disciplines. More and more programs are beginning to move back into the life of their professional communities. They are seeing themselves as part of that professional community and are assuming the duties and responsibilities that come with such membership. They are modeling not only a cross-fertilization of technology but a cross-fertilization of spirits, a mutuality of support among healers and change agents. Given the growing numbers of clients who present with multiple problems and problems with such great chronicity and intensity, programs of excellence are beginning to forge multi-disciplinary, multi-agency assessment and intervention models. They are declaring through their actions that the competition-driven isolation of the 1980s must give way to cooperation and collaboration as we move into the next century.

Programs of excellence are getting out of their buildings and into the life of the communities we serve. They are moving into the schools, and the churches and the neighborhood centers. They are regenerating the tentacles that once extended from their organizations deep into the heart of their communities. They are renewing an emphasis on service delivery in the client's home environment. They see themselves as organizers involved in building a vibrant culture of recovery within their local communities—a culture of recovery that can both attract and support their clients.

#### **F. Social Action**

The final strategy of organizational renewal is to break out of the institutionalized cowardice of the 1980s—a time when social conscience was abdicated and exchanged for personal and institutional self-interest. For the past decade, IADDA has often been a lone voice raising public policy issues that transcended our isolated interests as local programs. IADDA is being joined by a growing number of individuals and programs calling for a renewed activism. Renewal

through social action involves two dimensions: 1) confronting abuses within our own field that jeopardize the future accessibility, affordability and credibility of substance abuse prevention and treatment services, and 2) confronting the political, economic, and social conditions within which substance abuse is embedded.

In the first of these strategies we must in our organizations, professional associations and advocacy groups begin to define standards of professional and ethical conduct that will govern our business and clinical practices. We must confront the fact that external regulatory and fiscal controls that are compromising the availability and range of addiction treatment services emerged, in part, from exploitive practices within our own programs. We must begin to re-establish integrity to our clinical and business practices before reimbursable services for addiction treatment once again disappear from our health care system. That integrity must come from internal standards development and internal policing. It was as much the silence of the majority as it was the exploitive abuse of the minority that led to the external regulation of our field. We must elevate the level of our ethical standards and hold each other accountable to such standards.

If in our inventory of ourselves and our environment, we have our consciences pricked or punctured by conditions that promote addiction within our society, then we must cry out against such conditions. Our mission of service to the individual addict cannot be abandoned, nor can we let social or political action divert us from our primary task. Our continued silence, however, is unconscionable. We must add our personal and institutional voices to confront any economic, political or social pathologies that help initiate or sustain the personal pathology of addiction. To the extent that racism, sexism, homophobia and other exploitive and self-obliterating "isms" play a role in the etiology of addiction or constitute obstacles to recovery, they must become our issues. To the extent that poverty, homelessness, inadequate child care, inadequate health care or any other issues pose obstacles to initiating and sustaining recovery, they must become our issues.

There is another important and politically dangerous issue that we must face. To the extent that forces of drug promotion operate unchecked in our communities, this must become our issue. We must begin to confront the contradictions raised by the massive promotion of licit drugs in this culture. Those of us on the treatment side of our field must begin to add our voices to the

growing numbers of prevention professionals who are beginning to confront the massive promotion of tobacco, alcohol and other licit drugs to our citizenry. The practice of targeting—developing special products and promotional campaigns aimed at particular populations such as youth, women, people of color, the alcohol and drug dependent—is particularly offensive and must be confronted. As organized efforts and acts of civil disobedience to challenge such predatory drug promotion increase, it will be interesting to see where we as a field cast our lot. Will we help support or provide leadership to this movement? Will we be participants in this movement along side our community constituents? Or will we be bystanders, noticeable by our absence and our silence? If it is the latter, then we will deserve being called parasites and predators for our abdication of courage and conscience.

The revival of social action by programs of excellence is based on a disturbing self-realization—the realization that we are either agents of social change—instruments to alter the economic political and social structures that breed or exacerbate personal pathology—or we are parasites who feed on the problems of our clients and our communities to support our own material and emotional comfort. As substance abuse prevention and treatment professionals, we draw our sustenance from the addict's pain in no less measure than the drug dealer. Our homes, our cars, our clothes, our lifestyles—whether dealer or counselor, whether liquor wholesaler or nurse—are sustained by addiction. So what separates servant from predator? Predators have a vested interest in both sustaining the person-drug relationship and sustaining the social conditions that make that relationship so seductive and enduring. Servants seek to break the person-drug relationship *and* attack conditions that support this relationship. Predators peddle chains and justify or are silent on the issue of slavery. Servants break chains *and* attack the institution of slavery. It will be important for each organization in the 1990s to figure out if their essential character more closely resembles the predator or the servant?

#### ***IV. Closing***

I have tried to define what I consider to be a spiritual crisis spawned by many forces which have worked to divert us from our primary task. Our ability to confront such diversions and get refocused on our primary service mission is crucial for the renewal of the field. In the lexicon of the civil rights movement, we must keep our eyes on the prize. When you strip away all the

buildings and budgets, the policies and procedures, and the administrative and supervisory supports, the impact of the whole field comes down to the point of interaction between front line workers and our service consumers—whether they be citizens or clients. It is the transforming power of that point of contact that must be our perpetual focus. That's where the action's at. Everything else is secondary.

If there is any message that emerges from our history it is that individuals and individual programs of excellence can have a profound effect on the evolution and advancement of our field. Having that kind of effect requires both technical knowledge and skills and a passionate commitment to service. You will have great opportunity to seek out new knowledge as this conference proceeds. As you seek to enhance your technical knowledge, I would also charge you to seek out opportunities to refocus your professional values and commitments, to recapture that spirit of service that first drew you to this work.

I hope the re-emergence of service as the centerpiece of our field will be paralleled by similar processes of renewal in other health and human service disciplines. Perhaps even more importantly, I hope it is part of a broader process of cultural renewal through which we break out of the isolation and alienation of the past two decades and rediscover the values of social duty and public service and regenerate our connectedness to one another and our sense of community. I hope you and I can look back in the future and feel we were leaders in this broader professional and cultural movement.

I would like to leave you with these thoughts. There is no profession potentially more honorable and more fulfilling than our own. There is nothing more noble than promoting the health of individuals, families and communities. There is nothing more heroic than participating in the life-enriching transformation of another human being. We have the power through our prevention and treatment technologies to intersect with human beings and forever alter the trajectory of their lives. *If there are heroes and heroines in our culture right now, they're not on Wallstreet, they're in this room, and they're working today in the programs which each of you represents!*

**ABOUT THE AUTHOR**

**William L. White, M.A.**— Bill White has a Masters degree in Psychology and 27 years of experience in the health and human service field as a clinician, clinical director, administrator, researcher and well traveled trainer and consultant. He is currently a Senior Research Consultant at the Lighthouse Institute, a division of Chestnut Health Systems in Bloomington, Illinois. Bill spends more than 125 days each year providing training and consultation services to a wide variety of organizations throughout the country.

**THE LIGHTHOUSE INSTITUTE**

The Lighthouse Institute, a division of Chestnut Health Systems, offers advanced technical education and training for health and human service organizations and a wide variety of management training, consultation and research services available to organizations throughout the United States. The Institute also publishes books, curricula, and monographs on topics of high interest to its clients.



**Lighthouse Institute**  
*A Division of*  
**Chestnut Health Systems**

**Workshop/Publication Mailing List**

If you are interested in receiving announcements of LTI workshops and publications, please complete this card and return to:

**Lighthouse Institute, 702 W. Chestnut St., Bloomington, IL 61701**

*Please Print*

Name \_\_\_\_\_

Position \_\_\_\_\_

Agency \_\_\_\_\_

Bus. Address \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

This is my  business  residential address.

Please check areas of interest:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Aids             | <input type="checkbox"/> Domestic Violence  | <input type="checkbox"/> Special Populations |
| <input type="checkbox"/> Child Welfare    | <input type="checkbox"/> Mental Health      | <input type="checkbox"/> Substance Abuse     |
| <input type="checkbox"/> Criminal Justice | <input type="checkbox"/> Program Management | <input type="checkbox"/> Supervision         |

Other \_\_\_\_\_