Treatment Is Only the Beginning

How recovery capital supports lasting change

Completing treatment can look like a finish line. From a recovery perspective, it is only the beginning.

Carl Arline, CADTP, a substance use disorder counselor with Phoenix Houses of California (PHCA), put it plainly: “Once a participant completes treatment, that doesn’t mean that the job is done. The work is not finished. It is actually just beginning.”

Residential treatment can provide structure, clinical support and an environment in which people begin changing long-established patterns. But recovery ultimately has to work outside that environment: at home, at work, in relationships, in the community and during the ordinary pressures of everyday life.

Research increasingly supports this broader view of what recovery requires.

One framework receiving growing attention is recovery capital: the personal, social and community resources people can draw on to initiate and sustain recovery. A 2024 systematic review of 69 studies involving more than 60,000 participants identified 41 different recovery-

capital constructs, reflecting just how broadly researchers now understand the resources, strengths and supports that can shape recovery over time. [1]

The question is not only whether someone completed treatment. It is also: What have they built within themselves, and what supports surround them, to sustain recovery when treatment ends?

Building the capacity for recovery

For many people preparing to leave residential treatment, one of the hardest challenges begins internally.

Clients may have learned coping strategies, practiced healthier communication, navigated conflict differently and begun making decisions that once seemed out of reach. Yet knowing how to do something is not the same as trusting yourself to do it when the structure around you changes.

Caitlan McHenry, LPCC, described that internal work as foundational: “The work begins within the person — building confidence, self-esteem and self-worth. That foundation is what allows someone to use the skills they’ve learned when they return to work, family, relationships and everyday life.”

Research on substance use treatment has long identified self-efficacy, a person’s confidence in their ability to carry out the behaviors needed to support recovery, as an important factor in treatment outcomes. [2] A 2026 systematic review and meta-analysis of 61 studies involving 18,693 people following residential substance use treatment reinforced that connection, finding higher self-efficacy among people who remained abstinent than among those who relapsed. [3]

Building self-efficacy means helping people recognize their strengths, practice new responses and develop confidence in their ability to navigate difficult situations.

Several evidence-based approaches used by PHCA reinforce that work.

Motivational Interviewing is collaborative and person-centered, helping individuals explore their own reasons for change, work through uncertainty and strengthen motivation to take positive steps. SAMHSA describes MI as an approach designed to strengthen a person's motivation and commitment to change by exploring their own reasons within an atmosphere of acceptance and compassion. [4]

Cognitive-Behavioral Interventions for Substance Abuse (CBI-SA) builds another layer of practical confidence by helping clients identify triggers, manage cravings and urges, strengthen self-control and practice skills for relapse prevention and long-term recovery.

For people whose substance use is intertwined with trauma, Seeking Safety provides present-focused strategies for coping, grounding and establishing greater safety without requiring them to recount detailed trauma histories.

Relapse literacy is also part of building the capacity for recovery: understanding that setbacks can occur, recognizing the circumstances that may contribute to them, and knowing how to re-engage with treatment and support rather than viewing relapse as a failure.

> Relapse is part of recovery. What matters is how long someone stays down and how quickly they are able to get back up and re-engage in their recovery.
>
> **DENICE HUTNER, LMFT**
> SENIOR PROGRAM DIRECTOR, PHOENIX HOUSES OF CALIFORNIA

The National Institute on Drug Abuse emphasizes that relapse does not mean treatment has failed. A return to substance use can indicate that treatment needs to be resumed, modified or strengthened. [5]

Denice Hutner, LMFT, senior program director at PHCA, was unequivocal: “Relapse is part of recovery. What matters is how long someone stays down and how quickly they are able to get back up and re-engage in their recovery.”

The goal is not to minimize relapse, but to help people recognize what contributed to it, re-engage support and continue moving forward in recovery.

Building the capacity for recovery extends beyond internal strengths and skills. It also requires continuing care and practical resources after treatment, treatment organizations capable of providing and coordinating those resources, and peers who bring lived experience to the recovery process.

Recovery depends on what surrounds the person

Someone can leave treatment deeply committed to change and still face unstable housing, unemployment, untreated medical or mental health needs, lack of transportation, fractured relationships or difficulty accessing the next level of care.

Those are not peripheral issues. They are part of the environment in which recovery has to survive.

“Continuing care starts at the onset of services,” said Hutner. “From the beginning, we are thinking about what each person will need to sustain recovery after residential treatment and engage them in that process.”

At PHCA, that planning can involve securing necessary documents and benefits, preparing for employment, addressing medical and behavioral health needs, identifying stable housing, connecting to outpatient treatment or determining whether a sober living environment is the appropriate next step.

Clients participate in that planning. They are asked what they believe their next steps should be and are given information to help them make informed decisions rather than simply receiving a plan created for them.

Research on continuing care supports taking that longer view. Reviews have generally found benefits from continued care following an initial period of substance use treatment, although effects vary. Longer-duration approaches and those that actively work to keep people engaged have tended to produce more consistently positive results. [6]

The broader lesson is that treatment programs cannot wait until the final days of residential care to ask what will happen next.

The next phase of recovery is already part of treatment.

Supporting recovery beyond residential care also requires treatment organizations to work across programs and systems.

No individual clinician, program or facility can provide every resource a person may need. Housing, physical health, mental health, employment, outpatient treatment, benefits, family services and recovery support frequently cross organizational and geographic boundaries.

For treatment providers, continuity of care therefore depends in part on the ability to collaborate across programs and systems.

That is an area PHCA staff identified as a particular organizational strength.

Arline, who has worked in other treatment settings, described the difference he has experienced at PHCA: “What stands out is the level of collaboration and support. We can reach across the organization to program directors, clinical managers and colleagues with different areas of expertise and get insight, resources and help when we need it.”

That organizational exchange creates a larger pool of expertise than any single site could develop on its own. Programs serving different populations and communities encounter different needs. Clinicians bring different professional backgrounds and areas of expertise. Resources developed in one program can inform work elsewhere.

For government agencies, community organizations and other partners, that capacity matters. Collaboration is not simply an internal cultural value. It strengthens the organization’s ability to respond to changing client needs, connect people to appropriate resources and draw on expertise from across PHCA’s programs.

Hutner described it as modeling the same principle the organization asks clients to practice: “We try to embody the same message we give our clients: ask for help, work together and use the resources around you.”

Recovery depends on learning to seek help, build relationships and use available resources. Treatment organizations need to be capable of doing the same.

> We try to embody the same message we give our clients: ask for help, work together and use the resources around you.
>
> **DENICE HUTNER, LMFT**
> SENIOR PROGRAM DIRECTOR, PHOENIX HOUSES OF CALIFORNIA

For clients, one of the most immediate resources available within treatment is the support of a peer who has walked a similar path.

At PHCA’s Victorville residential program, every new client is paired with a more experienced peer through its ‘Big Buddy’ system. The peer helps welcome the person into the program, introduces them to the environment and supports their participation in treatment.

But the value of peer support reaches beyond orientation.

Hutner described the difference this way: “There is something powerful about hearing from someone who has been through a similar experience. It creates a different level of trust and hope: *if you can do it, maybe I can too*.”

Peers can provide a kind of credibility that is different from clinical expertise or family support. They can become a sounding board and a mirror, helping someone recognize changes they may not yet see in themselves.

That relationship can benefit both people. The client sees recovery being practiced by someone beside them. The peer providing support gains responsibility, purpose and an opportunity to recognize how far they have come.

Research into peer recovery support is still developing, but the evidence is becoming clearer in some areas. A 2025 systematic review examined 28 studies involving 12,601 participants and found increasingly consistent evidence that peer recovery support can improve treatment engagement and retention. [7]

Peer support adds something clinical treatment cannot always replicate: shared experience, identification and the visible possibility of change.

Recovery changes the family system

Recovery inevitably changes the relationships around a person, particularly within the family.

Families understandably may hope that completing treatment means the crisis is over and life can return to normal. But “normal” may include relationship patterns, expectations or conflicts that developed over years.

When one person changes, the family system changes with them.

PHCA clinicians described family dynamics as factors that can increase risk or, when addressed, become protective. Family members may need education about substance use disorders, their own support or therapy, healthier boundaries and a willingness to examine how they participate in relationships that are changing.

McHenry put it directly: “Recovery changes the family system, not just the individual. Family members may also need to look at their own roles and patterns, get support or education, and consider how they can participate differently in the relationship.”

That does not mean every family member will participate.

Part of treatment can involve helping clients accept that reality as well. A person in recovery may change while a parent, partner or sibling does not. They may have to stop waiting for an apology

that never comes, change expectations of a relationship or learn how to maintain recovery even when someone else remains exactly as they were.

Returning to the same world does not have to mean returning to the same patterns. Sometimes recovery requires creating new ones.

Residential treatment can create an essential period of stability in which change begins. The larger task is preparing people to carry that change into a world that will not be as controlled, predictable or protected.

Arline's observation brings the argument back to its starting point: completing treatment does not mean the work is finished.

In many ways, the work is just beginning.

The question is not only whether someone completed treatment.

It is whether they leave with the skills, supports and resources to sustain recovery when they do.

SOURCES

[1] Adela Bunaciu et al., **"Measuring recovery capital for people recovering from alcohol and drug addiction: A systematic review,"** *Addiction Research & Theory*, 2024.

[2] Ronald M. Kadden and Mark D. Litt, **"The Role of Self-Efficacy in the Treatment of Substance Use Disorders,"** *Addictive Behaviors,* 2011.

[3] Sajid Naeem, Amna Rasheed and Hasnain Ali, **"Risk and Protective Factors for Relapse After Residential Substance Use Treatment: A Systematic Review and Meta-Analysis,"** *BMC Psychiatry*, 2026.

[4] **Substance Abuse and Mental Health Services Administration, Using Motivational Interviewing in Substance Use Disorder Treatment**, updated Sept. 17, 2026.

[5] National Institute on ***Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction***, section on relapse and treatment.

[6] James R. McKay, **"Impact of Continuing Care on Recovery From Substance Use Disorder,"** *Alcohol Research: Current Reviews*, 2021; and Janet C. Blodgett et al., **"How effective is continuing care for substance use disorders? A meta-analytic review,"** *Journal of Substance Abuse Treatment*, 2014.

[7] David Eddie et al., **"Peer Recovery Support Services and Recovery Coaching for Substance Use Disorder: A Systematic Review,"** *Current Addiction Reports*, 2025.