DIGESTING THE EVIDENCE

By Dr. David Best

CONTENTS

DIGESTING THE EVIDENCE

David Best (Chair, Scottish Drugs Recovery Consortium; Reader in Criminal Justice, University of West of Scotland), Alexandre Laudet (Center for the Study of Addictions and Recovery, National Development and Research Institutes, Inc.)

The growth of interest in addictions recovery in the UK is relatively recent and the growth of a recovery movement has brought to light a new set of questions and concerns which are consistent with the emergence of a 'paradigm shift' in thinking from an acute care model of addiction to a developmental model of recovery oriented thinking.

However, it is crucial that we do not under-estimate what we already know about recovery. We have a number of primary sources which we can draw upon:

- **A history of research around mutual aid and community focused interventions, albeit relatively little of this is from the UK;**
- **Research into mental health recovery including a substantial body of work from Scotland;**
- **Studies of 'natural recovery' from addictions;**
- **Treatment outcome and cohort studies, including a recent Scottish study;**
- **A growing body of UK (including Scottish) research which is focused exclusively on increasing our understanding of recovery models and recovery pathways.**

The purpose of this document is to summarise some of this knowledge and to provide a sense of direction for where future research and evaluation efforts need to be focused. In Scotland, there is a growing diversity and richness of recovery activity and innovation. Researchers and commissioners are struggling to keep pace with this creativity and dynamism. 'Digesting the Evidence' is intended to complement the work done by Best and colleagues (2010) reviewing the evidence base for The Road to Recovery strategy, but as that document has quickly become dated so too will this one. This is a testament to the rapidity of growth of recovery activity and the body of knowledge which underpins this.

Ultimately this document is intended to make a very clear statement – recovery is an evidence-based approach that, while not always amenable to the traditional research methods of randomised clinical trials – has used a wide range of research techniques to demonstrate not only that people can and do recover but what can be done to maximise the chances of this happening and to support individuals, their families and their communities.

SECTION 1:
ABOUT RECOVERY

1: Recovery definition and principles

The UK Drug Policy Commission convened a meeting of senior UK practitioners and academics, people in recovery and family members to develop a UK 'vision' of recovery. Recovery was characterised as a process of 'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' (UK Drug Policy Commission, 2008, p.6). The report emphasises the range of routes to recovery and also suggests that this includes 'medically maintained abstinence' (UKDPC, 2008, p.6). In *The Road to Recovery* (Scottish Government, 2008), recovery is defined as 'a process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society.' The Report went on to declare that 'recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment....an aspirational and person-centred process' (Scottish Government, 2008, p.23).

In the United States, the Betty Ford Institute Consensus Panel (2007, p.222) defined recovery as 'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship.' The Consensus Panel further detailed the meaning of sobriety by explicitly stating that 'formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other non-prescribed drugs would meet this definition of sobriety' (p.224). The Panel further differentiated the stages of recovery as 'early sobriety' (the first year), 'sustained sobriety' (between 1 and 5 years), and 'stable sobriety' (more than five years).

A different type of definition comes from a key recovery advocate from the mental health field, Pat Deegan, who has argued that 'recovery refers to the lived experience of people as they accept and overcome the challenge of disability... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability' (Deegan, 1998). How is this reconcilable with the above definitions that focus on thresholds and criteria? The challenge is that recovery is a lived experience that is not readily amenable to external observation or validation. As there is no single pathway to recovery, people will experience different conditions and critera at differing stages of their recovery journey. The notion of a journey is also important to many people and there are traditions which would define recovery as an ongoing process rather than an end state.

The Centre for Substance Abuse Treatment (2009) have avoided the idea of a consensual definition in favour of a series of principles:

- **There are many pathways to recovery;**
- **Recovery is self-directed and empowering;**
- **Recovery involves a personal recognition of the need for change and transformation;**
- **Recovery is holistic;**
- **Recovery has cultural dimensions;**
- **Recovery exists on a continuum of improved health and wellbeing;**
- **Recovery emerges from hope and gratitude;**
- **Recovery involves a process of healing and self-redefinition;**
- **Recovery involves addressing discrimination and transcending shame and stigma;**
- **Recovery is supported by peers and allies;**
- **Recovery involves rejoining and rebuilding a life in the community;**
- **Recovery is a reality.**

This approach does not utilise the same tripartite model of criteria, but creates a more fluid and personal set of guiding principles (a similar set of criteria are established for recovery-oriented systems and are outlined overleaf). This should avoid the unhelpful debates about what constitutes 'abstinence' (including the questions about whether methadone maintained clients or drinkers who switch from dependent to 'controlled' drinking can be included), and similar debates about what the threshold is for 'citizenship' (and the extent to which this involves actively job seeking).

The key conclusions from this section are that recovery is a personal process which may evolve over time (White and Kurtz [2006] has estimated that the recovery journey typically takes 5-7 years for heroin users while Edwards [2000] has argued for a period of 4-5 years since the last drink for alcoholics). This also implies that it is not in the gift of the 'expert' (be they clinician or academic) to confer a status of recovery as if it were a diagnostic category. Finally, what recovery will look like will be contextually bound by culture and community. If a definition is required a more appropriate working definition for helping agencies and administrators may be 'maximising the opportunity to fulfil personal and social capabilities'.

Key points

Definitions of recovery have typically involved abstinence from illicit drugs and alcohol, improvements in global health and quality of life, and community involvement.

However, there is a philosophical problem with definitions as recovery is a personal and ongoing journey for many people.

There are alternative approaches around principles which may be more helpful than definitions.

2: Rates and predictors of recovery

According to William White, recovery is the rule rather than the exception: most (50% or more) people with significant alcohol or other drug (AOD) problems (meeting diagnostic criteria for a substance use disorder) will eventually resolve those problems (See White, 2008a for a review). In the review of recovery evidence by the Centre for Substance Abuse Treatment (2009), the overall estimate of the proportion of those with a lifetime substance dependence who will eventually achieve recovery is 58%. This estimate is based on epidemiological studies looking at treatment and non-treatment populations and will include self-report rather than diagnostic evidence.

The outcomes reported from treatment populations are very different. Data on prospective treatment outcomes for drug users date back to the DARP study in the US (Simpson and Sells, 1990) which investigated four different treatment modalities and involved follow-up windows of up to 12 years, showing that among those patients who had been daily users of opioids before treatment, more than half (53%) reported no daily opioid use at one year. Opioid use continued to decline over time until year 6, when it stabilised at 40% for 'any' use and 25% for 'daily' use. At some point during the 12 years following treatment, three quarters of the sample had relapsed to daily opioid use, but at the year 12 interview, nearly two thirds (63%) had not used opioids on a daily basis for a period of at least 3 years. Subsequent large-scale US follow-up studies (TOPS, Hubbard et al, 1989; DATOS, Flynn et al, 1997) continued to show positive gains across treatment modalities, that were subsequently replicated in an English (NTORS, Gossop et al, 2005) and Scottish (DORIS, McKeganey et al, 2003) treatment setting.

Why is it the case that the outcomes are so much poorer for treatment studies than for population research? Part of this is explained by the selection bias in treatment studies – as Robins [1993] argued, when reporting the low rates of ongoing problems and treatment seeking in problematic heroin using veterans returning from Vietnam, people who seek specialist drug treatment usually have a wide range of problems which are not restricted to their drug use – they may have crime problems, health problems and a range of other social and lifestyle issues by the time they arrive at treatment services' front doors. A sample of 898 men who had returned from Vietnam in 1971 was interviewed in 1972 from eight to 12 months after their return. Approximately 20% of the enlisted men had dependent use of heroin whilst in Vietnam. Upon return, only 10% reported using drugs between the time of their return and the interview and only 1% had been re-addicted. At the time of the interview, only 2% (8% of those who were dependent users in Vietnam) had reported continued drug use (Robins, 1993).

The prognosis for long-term recovery varies markedly by degree of problem severity and by personal, family and community recovery capital (White, 2009b; Granfield & Cloud, 1999, 2001). There is a growing body of scientific literature that assumes stage theories of addiction recovery (DeLeon, 1996, 2007; Frykholm, 1985; Klingemann, 1991; Prochaska, DiClimente & Norcross, 1992; Shaffer & Jones, 1989; Waldorf, 1983; Waldorf, Reinarman & Murphy, 1991).

When research on recovery stages is viewed as a whole, four broad stages of recovery are evident:

1) **Pre-recovery problem identification and internal/external resource mobilisation destabilisation of addiction and recovery priming;**

2) **Recovery initiation and stabilisation;**

3) **Recovery maintenance;**

4) **Enhancements in quality of personal/family life in long-term recovery and across the personal/family life cycle.**

Due to the higher visibility of 'chronic, relapsing' drug using populations in treatment there is a risk (referred to by Gossop [2007] as the 'clinical fallacy') to assume that this is the nature of addiction and that once dependent; addicted people do not recover. Yet the evidence from population studies and synthesised by CSAT (2009) would suggest that this is not the case, and that the establishment of personal and social supports (described as 'recovery capital' below) can alter these long-term outcomes significantly.

There is, however, a caveat to this optimistic prognosis. In a 33-year outcome study conducted in the US, Hser and colleagues (2001; 2007) found that self-efficacy and psychological wellbeing were predictors of stable recovery. The authors emphasised key developmental concepts such as trajectories and turning points, although they conceded that there was a dearth of information about cessation factors. One of their observations was that career pathways appeared to differ for different substances, with cocaine use increasing through the 20's to early 30's and then declining, but heroin use continuing to increase. In terms of the typology of heroin users developed by Hser and colleagues (2007), the authors differentiated between stable high-level users, decelerating users and early quitters. The last group (who constituted just under half of their longitudinal sample) had heroin careers of typically less than ten years. This early quitting population of heroin users had higher frequencies of use in the first 2-3 years of use but then showed marked reductions and were abstinent by year 11.

Similarly, there is no cut-off beyond which clients are 'safe' from relapse risk. In 2007, Dennis, Foss and Scott reported on 8-year outcomes among a cohort of 1,326 substance users accessing treatment services – at the 8-year follow-up point, 501 were abstinent from alcohol and illicit drugs (37.8%), of whom only 77 (15.4%) had been abstinent for five years or more. A total of 142 individuals (10.7% of the total sample) had been abstinent for at least 3 years. Increasing duration of abstinence was associated with more days in employment, fewer debts and fewer days of incarceration.

Key points

The epidemiological evidence would suggest that 58% of people with a lifetime dependence will achieve lifetime recovery.

However, rates vary by population, by drug use profile and by levels of recovery capital.

High rates of recovery are reported in general population studies.

3: Natural recovery

The notion of people overcoming addiction problems without formal assistance has been subject to some academic analysis. Thus, where the evidence is based on household surveys assessing the rates of 'natural recovery' (generally defined as recovery without seeking specialist treatment) Sobell, Campbell and Sobell (1996) reported rates of 75% and 77% recovery without formal help in drinkers in remission. Cunningham (2000) assessed recovery from a range of substances and reported that the use of any formal treatment ranged from 43.1% for cannabis to 90.7% for heroin, with 59.7% of cocaine users seeking formal treatment at some point in their recovery journeys.

Klingemann (1991), in a qualitative study of 30 formerly alcohol dependent and 30 formerly heroin-dependent users in Switzerland in 1988, identified a typology of motivation to stop characterising three major stages of the 'autoremission' process. At first, in the language of Alcoholics Anonymous (AA), one group in recovery was described as 'hitting bottom', e.g. experiencing physical, interpersonal, and psychological collapse. Within this group, one sub-sample was characterised by Klingemann as 'cross-road types', who act on the basis of a single crisis (such as health or psychological problems); another sub-sample consisted of 'pressure-sensitive types', who reacted positively to social pressure which forced them to choose between a life of conformity or an addiction career. In contrast to the 'hitting bottom' group, which could usually define a specific turning point, another group was characterised as slowly and harmoniously drifting out of addiction. Their motivation to quit was based on positive changes in their social environment. Yet another group was described as having had esoteric or religious experiences as turning points.

Granfield and Cloud (2001) assessed natural recovery using semi-structured interviews with 46 formerly drug or alcohol dependent persons who have recovered without treatment for their substance dependencies, including participation in 12-step groups. Many of the participants in their study felt that the 'ideological' base of some self-help programs was inconsistent with their own philosophies of life. The subjects in the study by Granfield and Cloud (2001) also felt that some self-help groups encouraged dependence, and that associating with other alcoholics would probably make recovery more difficult. In summarising their findings, Granfield and Cloud (2001) reported that the respondents in their study discounted the use of self-help groups because they saw themselves as 'efficacious people who often prided themselves on their past accomplishments'. Granfield and Cloud (2001) added to the social context notion of recovery by noting that many of the respondents in their sample had a great deal to lose if they continued their substance abuse. They noted that the subjects in their study 'had jobs, supportive families, high school and college credentials, and other social supports that gave them reasons to alter their drug-taking behaviour,' and add that 'having much to lose' gave their respondents 'incentives to transform their lives' (p. 55). Granfield and Cloud also emphasise the importance of establishing a 'post-addict identity' which allows people to move away from the trappings of their addiction lifestyle and the related social network.

Waldorf, Reinarman, and Murphy (1991), based on 267 in-depth interviews with heavy cocaine users, found that many addicted people with supportive elements in their lives (a job, family, and other close emotional supports) were able to 'walk away' from their very heavy use of cocaine. The authors suggested that the 'social context' of drug users' lives might positively influence their ability to discontinue drug use. Biernacki (1986) reported on a range of strategies used in natural recovery including:

- **Breaking off relationships with other drug users;**
- **Removing oneself from a drug-using environment;**
- **Building new structures in one's life;**
- **Using social networks of friends and family to provide support for the newly emerging recovery status.**

In their recent review, Klingemann, Sobell and Sobell (2010) conclude that studies of natural recovery suggest the relevance of concepts of drifting and 'maturing out'. They also challenge the assumption that natural recovery is less likely to occur in more severe cases of substance use and suggest that this is a key area of natural recovery research.

Key points

Natural remission rates for drinkers range from 75-77% in Canadian population studies.

For natural recovery, the start of the process does not require hitting rock bottom.

Successful strategies include moving away from old social networks, and engaging the support of family and friends to establish a new identity.

The establishment of a 'post-addiction identity' is critical in this process.

4: Recovery capital

Granfield and Cloud (2008) define recovery capital as 'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems'. Granfield and Cloud have argued that people who have access to greater reserves of recovery capital are better able to address problems than those who do not have such access. In their 2010 report on 'Whole Person Recovery', the Royal Society for the Arts have outlined what they consider to be the core components of recovery capital:

- **Housing;**
- **Physical and mental health;**
- **Purposeful activity: education, training and employment;**
- **Peer support;**
- **Family and friends.**

In the above list, the first three of these would be regarded as 'personal' recovery capital and the last two as 'social recovery capital' – in other words, recovery capital does not merely apply to 'traits' or personal strengths but also to what social supports they can draw upon. The RSA report also talks of 'Community Recovery Capital' by which they are referring to:

- **Low levels of stigmatisation and negative labelling;**
- **Community resources such as transport links and the quality and availability of public spaces;**
- **Local recovery communities which include the groups and agencies which promote community engagement in those experiencing recovery.**

Along similar lines, Best and Laudet (2010) have argued that 'Recovery unfolds in the lived, physical community as well as in the substance using communities and it has significant ramifications for those communities. The growth of recovery capital as a collective, community concept will involve mutual empowerment, support and recovery contagion in substance using groups, but it will manifest itself in improved functioning for the family and the wider community. The growth of recovery capital is, as far as we currently know, idiosyncratic and personal, but its manifestation is inherently social and community-based and its impact can be measured in terms of those lived communities'.

Collective recovery capital is based on the idea that recovery is contagious and that people who are exposed to individuals and groups who are embodying the recovery experience are more likely to be influenced and to benefit from this model. This is predicated on work in social epidemiology by Christakis and Fowler (2006) who have assessed the impact of social networks

on a range of health and lifestyle behaviours, in up to three degrees of separation from a target individual. For example, a person's odds of becoming obese increased by 57% if they had a friend who became obese, with a lower risk rate for friends of friends, lower again at three degrees of separation and with no discernible effect at further levels of removal. Moreover, if the friend is perceived to be a close friend then the risk rate is increased. Repeating this social network model using the same dataset for smoking, Christakis and Fowler (2008) found that smoking cessation by a spouse decreased a person's chances of smoking by 67%, while smoking cessation by a friend decreased the chances by 36%. The average risk of smoking at one degree of separation (i.e. smoking by a friend) was 61% higher, 29% higher at two degrees of separation and 11% higher at three degrees of separation.

In other words, the likelihood of recovery is greatly enhanced if the person has access to recovery champions and recovery groups who can be integrated into their daily routines. In contrast, individuals who are surrounded by active addiction have a powerful social draw to that lifestyle. For this reason, it is important that attempts to improve social capital build on the three levels of support:

- **Personal recovery capital;**
- **Social recovery capital;**
- **Collective or community recovery capital.**

In addition, the idea of strengths as a core predictor of outcome is increasing in prominence. White and Cloud (2008) have reviewed evidence to suggest that a better predictor of long-term outcomes and long-term recovery than pathology levels or measures of multiple morbidity is recovery capital. Therefore, programmes that aim to build recovery capital are more likely to experience long-term success.

Key points

It is the sum of personal and social resources that an individual can accrue.

This is supplemented by the collective recovery capital resources available in the community.

Recovery capital strengths is a strong predictor of long-term recovery outcomes.

5: Collective recovery capital and recovery in communities

The primary argument here is that recovery capital is not something that should be thought of as residing only in individuals. The idea of collective recovery capital (Best and Laudet, 2010) is that there is something measurable at a community level about the resources available to support recovery journeys. This is likely to be a sum of the recovery groups and the recovery champions available to support individuals at different stages of their recovery journey.

While this is linked to treatment support systems, in particular their assertive outreach and aftercare models, the core component of this is likely to be community and peer-based. White (2008) has argued that there are three pillars to effective communities of recovery:

- **Opportunities for education, training and employment;**
- **Access to safe and supported accommodation with the level of support linked to the individual's recovery stage;**
- **Access to peer-based recovery support systems.**

The evidence for effectiveness of peer-based interventions derives in part from a series of studies that looks at Recovery Management Check-up approaches. Scott and Dennis (2009) operationalised recovery management check-ups as quarterly check-ups supplemented by motivational interviewing, treatment linkage and provision of ongoing support. Compared with control clients, participants receiving Recovery Management Check-ups reported more days of abstinence, fewer symptoms of dependence or drug-induced problems and were more effectively engaged in treatment. The authors concluded that 'ongoing monitoring, feedback and early re-intervention can be effective methods managing recovery over time' (Scott and Dennis, 2009, p.969). This model also provides considerable optimism about the possibility of peer-driven recovery management check-ups in which those in recovery deliver the intervention and monitor and support peers earlier in the recovery process.

Another clinical trial method was used by Litt and colleagues (2007) who assessed the benefits of randomising people to 'network support'. They found that, of 186 participants randomised to network support (NS), case management (CM) or network support plus contingency management (NS+CM), participants in both network support conditions had better outcomes than case management alone. The authors found that 'The addition of just one abstinent person to a social network increased the probability of abstinence for the next year by 27%' (Litt et al, 2007, p.230).

In a follow-up to this study in 2009, Litt and colleagues reported 2 year post-treatment outcomes in 210 alcohol-dependent men and women randomised as above to network support (with or without contingency management) or case management. The network support only condition yielded up to 20% more days abstinent at two years than either of the other conditions. The authors also found that changes in social networks to include others in recovery were associated with increases in self-efficacy and coping that were strongly linked to better drinking outcomes. Most of the positive network changes were linked to 12-step attendance leading the authors to conclude that 'AA attendance and increasing the number of non-drinking friends in the social network were strong (direct and indirect) predictors of outcome, appearing to result in increased abstinence in part due to the effects on self-efficacy' (Litt et al, 2009, p.241).

The above studies have some crucial implications for the recovery agenda. The first is that social networks are critical mediators of drinking outcomes and that these can be changed by an intervention that is specifically designed to do so. The effects of changing social networks are really powerful with the study findings suggesting that significant changes in drinking result from incorporation of abstinent networks, a finding that is entirely consistent with the work on natural recovery and on long-term addiction careers.

Key points

Changing social networks impact on risks of substance use relapse.

The addition of just one abstinent person to a social network increased the probability of abstinence for the next year by 27%.

Engaging in abstinent social networks also results in increases in self-efficacy and coping skills.

Programmes designed to enable support for recovering individuals by recovery management check-ups increase recovery rates and also improve treatment re-engagement if relapse occurs.

SECTION 2:
RECOVERY PROMOTING SERVICES AND SUPPORTS

6: Models of recovery and change

The developmental model of addiction (Hser et al, 2007) is based on the idea of addiction as a 'career' which has a natural trajectory. In this model career is defined as a process in which drug use 'often escalates to more severe levels, with repeated cycles of cessation and relapse occurring over an extended period'. Hser and colleagues argued that life course or developmental models are characterised by trajectories as pathways and transitions as life events which may change the direction or pathway. Within an addictions model, the change assumption is that natural opportunities for change – moving house, getting a job, the birth of a child or the start of a new relationship – create a window of opportunity for change, and whether this is taken up or not will depend on the individual's recovery capital – or the resources they have to move forward in their lives. As Anglin and colleagues (1997) have argued with regard to the effects of marriage, it will depend on the drug using status of the partner and the timing and the duration of the marriage.

In their 33-year outcome study, Hser and colleagues (2007) identified three groups of heroin users – (1) stable high-level heroin users who maintained fairly high levels of use from initiation to the 33-year follow-up point, (2) decelerated users, who started at a high level but gradually reduced over time, and (3) early quitters, who quickly reduced to no use within the first 10 years of their initiation. This group only constituted 9% of their sample and even for this group, it took around 8 to 10 years before stable recovery occurred.

The origins of this model are in the developmental crime perspective in which the idea of 'maturing out' (Winick, 1962) is based on natural life events. In Charles Winick's analysis of substance use and offending, he observed that a large proportion of substance users did not reappear in treatment or criminal justice data beyond their late 30's. Although this model has been challenged, it is consistent with the work of Laub and Sampson on (2004) who followed up a group of young offenders from Boston to the age of 70. In this longitudinal cohort study, the long-term predictors of desistance of offending careers were:

- **Stable employment;**
- **Attachment to a conventional person (spouse);**
- **Transformation of personal identity;**
- **Ageing;**
- **Inter-personal skills;**
- **Life and coping skills.**

What was also extremely important in the Laub and Sampson study was that the level of risk factors at the adolescent stage had almost no predictive power around desistance. At the heart of a developmental model is the idea that there are 'turning points' that are generally key life events such as the development of new relationships, changes in living arrangements, changes in employment status and so on which create windows of opportunity for lasting change. This model would suggest that interventions are only effective to the extent that they can enable fundamental changes in life trajectories.

In their work on recovery journeys, outlined in the book 'Beating the Dragon', McIntosh and McKeganey (2000) describe 70 recovery experiences and conclude that the core transition to recovery is around the restoration of a 'spoiled identity'. Among the key desistance factors identified were developing new activities and relationships and developing a commitment towards new and changed lifestyles, at least in part by developing an identity as a non-addict. The authors identified two main mechanisms by which former users avoided relapse – '(1) the avoidance of their former drug-using network and friends and (2) the development of a set of non-drug-related activities and relationships' (McIntosh and McKeganey, 2000).

Shewan and Dalgarno (2005), in a longitudinal study of 126 non-treatment heroin users in Glasgow between 1996 – 2000, stressed the importance of the broader social environment while exploring patterns and trends of controlling as a component of 'unobtrusive' heroin use. The participants they described in the study were typically experienced users of heroin, amongst a range of other drugs. Virtually the complete sample (n=124, 98%) were heroin users, who have been taking the drug for 9 years. In contrast to typical samples of heroin users levels of educational achievement and work status were high – 64% having progressed to levels of education beyond secondary school and 74% were employed – and comparable to those found in the general UK population. While problems with health and social factors such as family and employment were reported, ongoing problems were rare in this sample and heroin was not found to be a significant predictor of either context.

Key points

Only a proportion of users will ever develop problematic use.

If people are going to quit, it is disproportionately likely to happen early in the addiction career (first 10 years).

Recovery change is characterised by changes in lifestyle and functioning and changes in identity.

Change is predicted by key life events, and their impact will be determined by the personal and social capital the drug user has at that time.

7: The role of treatment in recovery

The Drug Abuse Reporting Programme (DARP) was conceived in 1968 to monitor and evaluate the emerging USA federal addiction treatment system. DARP collected admission records for 44,000 patients at entry to 52 treatment agencies. Data was collected through intake interviews, during-treatment progress reports, and a series of follow-up interviews from 3 to 12 years after treatment. Over 6,000 patients were selected to participate in the first wave of post-treatment follow-up interviews which were conducted, on average, 6 years after admission. A second wave of follow-ups was conducted with a sample of 697 addicts, approximately 12 years after admission, with a follow-up rate of 70% (Simpson and Sells, 1990). DARP investigated four treatment types as well as a comparison group which enrolled but never started treatment. The four treatments were methadone maintenance, residential therapeutic communities, outpatient drug free (services which rely on counselling with an emphasis on abstinence), and outpatient detoxification. Reductions were found in the use of opiates and other drugs after treatment across all of the treatment modalities. Among those patients who had been daily users of opioids before treatment, more than half (53%) reported no daily opioid use at one year. Opioid use continued to decline over time until year 6, when it stabilised at 40% for 'any' use and 25% for 'daily' use. At some point during the 12 years following treatment, three-quarters of the sample had relapsed to daily opioid use, but at the year 12 interview, nearly two thirds (63%) had not used opioids on a daily basis for a period of at least 3 years.

In the UK, the National Treatment Outcome Research Study (NTORS, Gossop et al, 1998) in England examined outcomes across four different types of drug treatment – methadone maintenance, methadone reduction, in-patient detoxification and residential rehabilitation. During 1995, 1075 patients were recruited from 54 treatment programmes. Patients presented with a range of extensive, chronic and serious drug-related problems. The most common drug problem was long-term opiate dependence, often in conjunction with polydrug and/or alcohol problems. In an analysis of two-year outcomes from the residential modalities of treatment, Gossop and colleagues (2001) reported that almost half (49%) were abstinent from heroin after 4-5 years compared to around one-third of community treatment clients, and the percentage of residential patients who were abstinent from all six illicit target drugs (heroin, crack cocaine, cocaine powder, amphetamine, non-prescribed methadone and non-prescribed benzodiazepines), had increased from 1% at intake to 38% after 4-5 years. This finding would suggest not only positive outcomes for abstinence-oriented treatments, but also that this effect persists over time.

The follow-up to NTORS in England – the Drug Treatment Outcomes Research Study (DTORS), used a 12-month window to assess treatment outcomes, supplemented by a qualitative assessment of 'treatment-related issues' and a costs effectiveness analysis. In total, 1,796 drug users were recruited from 342 agencies across England. Of the initial cohort, 1,131 were successfully followed up at 3-5 months and 504 at 11-13 months. Employment rates increased

from 9% at baseline to 11% at follow-up one and 16% at follow-up two – however, the proportion of participants classed as unable to work also increased over the course of the study follow-ups. Similarly, offending reduced from a self-reported level of 40% at baseline to 21% at first follow-up and 16% at second follow-up. The proportion of clients with children under 16 who had all their children living with them fell from 22% at baseline to 15% at first follow-up but then increased to 34% by the final follow-up. The conclusion was that DTORS outcomes were equivalent or more positive for treatment effectiveness than those found in NTORS. Among heroin users involved in the baseline interviews, 44% had stopped using at first follow-up and 49% had stopped using at second follow-up, and there were consistent reductions in all of the other major substances assessed over the course of the follow-up periods.

This effect was made much more explicit in the Scottish treatment outcomes study – Drug Outcome Research in Scotland (DORIS, McKeganey et al, date). This was a prospective cohort study which recruited 1,007 drug misusers from 33 agencies across Scotland, including five prisons. The study involved follow-up assessments at 8 months, 16 months and 33 months post-intake to the study, achieving a 70% follow-up rate at the 33-month follow-up point. While there are initial improvements to 8 months, these taper off at the subsequent follow-up points. McIntosh, et al (2008) reported that 20.1% of the follow-up sample at the final data collection point (140/695) had been in paid employment since the previous interview. The main predictors of achieving employment were being younger, having lower levels of involvement in crime and receiving support from the treatment agency with training and education or with obtaining a job. Treatment modality was not linked to employment status.

The authors concluded that, compared to other community programmes, residential rehabilitation clients were twice as likely to be abstinent at 33 months, while methadone maintenance treatment was associated with reductions in heroin use but was not successful in promoting abstinence. In a paper drawn from the study, McKeganey et al (2006) reported on 695 follow-ups at 33 months and found that only 5.9% of females and 9.0% of males were abstinent in the 90 days prior to interview.

A meta-analysis of drug treatment studies conducted by Prendergast et al (2002) included 78 studies conducted between 1965 and 1996. The analysis concluded that drug abuse treatment has a statistically and clinically meaningful ability to reduce both drug use and offending. The biggest predictor of crime reduction was the younger age of the samples and, for predicting reductions in drug use, the key predictor variables were about how well the treatment approach was implemented and where there was little commitment to a single theoretical approach. While treatment works, the outcomes have been around public health and public safety and it is important to recognise that a recovery agenda involves different outcomes and so will imply other ways of measuring effectiveness.

Key points

Treatment is generally effective particularly in reducing crime and substance use.

There are striking levels of effectiveness in the long-term from abstinence-oriented treatments with almost half of the NTORS clients entering in-patient detoxification or rehabilitation being opiate free at two years.

The effective treatments on employment and family functioning is variable.

There are also significant programme differences and concerns about the adequacy of delivery of psychological interventions in out-patient treatment settings.

8: Learning the lessons from mental health

In addition to the significant overlaps between substance misuse and mental health populations, the recovery movement in mental health has had a longer developmental process than its equivalent in addiction, although this does not account for the long history of mutual aid groups in the addictions field. While there are important parallels, these findings must be translated with caution. Nonetheless, there are some extremely encouraging findings – Repper (2003) has reported that at least 50% of those who experience serious ongoing mental health problems can gain and sustain employment with appropriate professional support, while it is estimated that between 40 and 60% of people with mental health problems manage to live successfully with their families.

In terms of the prevalence of recovery, Harding et al (1987) conducted a 32-year follow-up study of the most difficult to place third of a population of psychiatric in-patient residents – at the follow-up point 81% were able to look after themselves. Twenty-five percent were fully recovered and 41% showed significant improvements, while only 11% of people with severe and enduring mental illness did not show any improvement and remained within the treatment and support system. More recently Warner (2010) reviewed the evidence of recovery and reported, from over 100 studies, that 20% of schizophrenics make a complete recovery and 40% a 'social recovery' (defined as economic and residential independence and low social disruption), with work and empowerment two of the key features of the recovery process.

Predictors of recovery in mental health services: Kirkpatrick et al (2001) reported that professionals who project messages of hope are a greater help to their clients, and that clients confer extra value on professionals who are seen to go the extra mile and to act in the role of a critical friend (Berg and Kristiansen, 2004). This supplements the key finding by Norcross et al (2002) that the relationship between client and therapist accounts for the largest amount of variance in outcomes that is not accounted for by pre-admission client characteristics.

For the Scottish Recovery Network, Brown and Kandirikirira (2007) used a recovery narratives model as part of a methodology that acknowledges the uniqueness of the lived experience of people in recovery, and identified a range of both internal and external elements involved in recovery process. The internal elements included:

- **self-belief;**
- **belief that recovery is possible;**
- **meaningful activities in life;**
- **positive relationships;**
- **an understanding of the illness;**
- **active engagement in recovery strategies.**

Thornicroft (2006) has identified key strategies for promoting empowerment of service users:

- **ensure full participation in formulating care plans;**
- **provide access to Cognitive Behavioural Therapy (CBT) to address negative self-stigma;**
- **create user-led and user-run services;**
- **develop peer support worker roles in mental health services;**
- **advocate for employers to give positive credit for experiences of mental illness;**
- **support user-led evaluations of treatment and services.**

Key points

Around half of those with significant mental health problems can obtain and sustain employment with appropriate support.

In a 32-year outcome study of the most difficult to place mental health patients, around 25% achieved full recovery and around 40% functional recovery.

Recovery is typically associated with empowerment and with active engagement in meaningful activities.

SECTION 3:
RECOVERY COMMUNITIES

9: What is a recovery oriented system of care?

In 1999, the National Institute of Drug Abuse (NIDA) produced a research based guide on the Principles of Drug Addiction Treatment based on a review of the research evidence. It concluded that, amongst other things, no single treatment approach was suitable for all individuals, and that recovery from drug addiction can be a long-term process which may require multiple episodes of support and assistance. This multiplicity of supports involves a range of community support systems. Laudet, Savage and Mahmood (2002) and Scott, Dennis and Foss (2005) reported that these will include recovery coaches, 12-step programmes, and social and community support systems.

Within this community model, Humphreys and colleagues (1999) have shown that the processes of social support are crucial mediators in the transition from starting a recovery journey to maintaining long-term recovery and that where there are poor social supports, individuals are more at risk of relapse. How this is built into a system is characterised as a 'recovery-oriented system of care'. The Centre for Substance Abuse Treatment (2009) have outlined 17 evidence-based principles for a recovery-oriented system. They are:

- **Person-centred;**
- **Inclusive of family and other ally involvement;**
- **Individualised and comprehensive services across the lifespan;**
- **Services anchored in the community;**
- **Continuity of care;**
- **Partnership-consultant relationships;**
- **Strengths-based;**
- **Culturally responsive;**
- **Responsiveness to personal belief systems;**
- **Commitment to peer recovery support services;**
- **Inclusion of the voices and the experiences of recovering individuals and their families;**
- **Integrated services;**
- **System-wide education and training;**
- **Ongoing monitoring and outreach;**
- **Outcomes driven;**
- **Research based;**
- **Adequately and flexibly financed.**

In research support for the principles, The Centre for Substance Misuse and Treatment (2009) has reported that where recovery communities become established there must be adequate provision of housing, employment and social support. Employment and stable housing have also been found to improve self-esteem and to support reintegration into mainstream society. Another core evidenced aspect of a recovery-oriented system is continuity of care – Haggerty and colleagues (2003) have shown that for complex disorders which persist over long periods of time, it is essential clients have a full range of treatment options that they can select from to support and enable the long-term recovery journey. Gruber, Fleetwood and Herring (2001) have also shown that this is particularly important for the recovery of substance-affected families.

This also applies to the link between treatment services and recovery. Ilgen et al (2006) found that a positive therapeutic alliance counteracted the effects of low baseline self-efficacy and low motivation in some clients, while Carten (1996) has shown that positive working relationships including shared planning and positive staff engagement were associated with better recovery outcomes for substance-using mothers. This is linked to an evidence base which show that integrating care is an effective way of optimising outcomes and improving the cost-effectiveness of treatment (Weisner et al, 2001).

The review has identified more than 375 research studies which support the framework, principles, elements and implementation of recovery-oriented systems of care. Many of these principles are already utilised in Scotland but they are not central to how services are performance managed or evaluated and the operationalisation of both the individual principles and the systems model will be a clear benefit in establishing effective recovery orientation in Scotland.

Key points

Treatment will play a core role but will require continuity of care and strong, supportive therapeutic relationships.

Effective packages of recovery support rest on effective and timely access to recovery-compatible housing, to training, education and employment support and to peer-based recovery support systems.

There is a strong and consistent evidence base underpinning the effectiveness of recovery models for both individual clients and for overall treatment systems.

10: What is a recovery community?

There are two separate issues to deal with here – the first is the strong and supportive evidence around recovery support groups, particularly 12-step and the second is the more complex question of the generation of communities that have a wider recovery focus.

Recent studies confirm that participation in Alcoholics Anonymous (AA) is linked to four outcomes: remission of alcohol dependence (Kelly & Yeterian, 2008), enhancements in global health (Humphreys, 2004), reductions in alcohol-related social and health care costs (Humphreys and Moos, 1996; Humphreys and Moos, 2001; Humphreys and Moos, 2009) and a reduction in alcohol-related mortality (Timko et al, 2006). The largest alcohol outcome study, Project Match (Longabaugh et al, 2001), compared 12-step facilitation with cognitive-behavioural therapy and motivational enhancement therapy. While all three interventions produced comparable benefits, 12-step facilitation generated higher levels of abstinence at the 1 and 3-year outcome points. A much smaller body of evidence exists in relation to Narcotics Anonymous. Nonetheless, in the Drug Abuse Treatment Outcome Study (Simpson, Brown & Joe, 1997), post-treatment 12-step involvement was associated with better outcomes, while a similar finding was recorded for cocaine treatment (Weiss et al, 2005; Weiss et al, 2000).

The positive effects of AA within a treatment systems model are associated with several key factors, including:

1) **Clinician attitudes toward recovery support groups (Laudet & White, 2005);**
2) **The timing of linkage to AA (with in-treatment linkage proving more effective than linkage at treatment discharge (Weiss et al, 2000; Moos & Moos, 2004; Moos & Moos, 2006);**
3) **Assertive rather than passive linkage procedures (Timko et al, 2006; Passetti & Godley, 2008);**
4) **Individual-AA group matching (Atkins & Hawdon, 2007);**
5) **Number of meetings attended (Humphreys, Moos & Cohen, 1997);**
6) **Intensity of AA participation (Humphreys, Moos & Cohen, 1997; Montgomery, Miller & Tonigan, 1995);**
7) **The duration of AA participation (Kelly, Myers & Rodlico, 2008; Moos & Moos, 2005).**

Also noteworthy is the finding that completion of a course of professionally-directed addiction treatment and post-treatment participation with recovery mutual aid groups are more predictive of long-term recovery than either activity in isolation (Dawson et al, 2006; Fiorentine & Hillhouse, 2000).

AA's effects on long-term recovery are mediated by multiple mechanisms, including problem recognition and commitment to change (Morgenstern et al, 1997), sustained self-monitoring (Moos, 2008), increased spiritual orientation (Galanter, 2007; Zemore, Kaskutas & Ammon, 2004), enhanced coping skills (Humphreys et al, 1999), recognition of high risk situations and stressors (Moos, 2008), increased self-efficacy (Morgenstern et al, 1997), social support to offset the influence of pro-drinking social networks (Longabaugh et al, 1998; Bond, Kaskutas & Weisner, 2003; Kaskutas, Bond & Humphreys, 2002), and benefits to self from helping other alcoholics (Galanter, 2007; Witbrodt & Kaskutas, 2005).

In wider recovery terms, White, Evans and Lamb (2010) have argued that 'community recovery is a voluntary process through which a community uses the assertive resolution of AOD [alcohol and other drug] related problems as a vehicle for collective healing, community renewal and enhanced intergenerational resilience' (White, Evans and Lamb, 2010, p5). They go on to describe community recovery as 'strengthening the connective tissue' between those with alcohol or drug problems and those without such problems with the goal of restoring the quality of life in the community. The purpose of a recovery community is to contribute to that symbiotic process of individual growth and wellbeing embedded within a group setting which also has the goal of improving life in that community.

An often quoted example of this is the growth of recovery in the Shuswap tribal community in Alkali Lake, where alcohol problems had become deeply entrenched. The decision of a newly elected Chief of the Tribal community to address the alcohol problems in the group led to a series of measures including the arrest of bootleggers, challenging drunkenness among public officials, and reviving community traditions. This was supplemented by education and employment programmes for those in recovery. Over the course of the next 10 years, the prevalence of problem alcohol use dropped from nearly 100% to around 5%, based on the assumption that 'the community is the treatment centre'.

A larger scale transition project was undertaken in the city of Philadelphia and has been reported by Lamb and colleagues (2009). Starting in 2004, a recovery-focused systems transformation process was undertaken beginning with a process of listening to multiple stakeholders and then conducting an inventory of the existing system of care and the relationships within it. On this basis, a vision of change was developed – to create 'an integrated behavioural health care system which promotes recovery, resiliency and self-determination'. This in turn led to the establishment of a new set of values based on hope, respect, strength, transparency, inclusion, fidelity, honesty, candour, forgiveness, consistency and endurance. These principles and the resulting practices were then implemented within the specialist services run by the city, before partnership arrangements based on this approach could be generalised. At the time the article was written, the system had been in place for four years and involved extensive training, the introduction of new measures and instruments for recovery, recovery celebration events and the opening of a dedicated recovery centre. The authors recognise that this is an ongoing process of attempting to embed recovery 'deeper and broader' and to continue to develop an evidence base which evaluates and improves on the recovery system.

Key points

There is a consistent and strong support for outcomes associated with AA engagement.

AA engagement has been shown to lead to reductions in alcohol related mortality, improvements in global health, reductions in alcohol dependence and reductions in alcohol-related costs.

There is a smaller but supportive evidence base around NA and also around SMART recovery. There is growing evidence that increasing the number of people in recovery will have a positive impact on community wellbeing and possibly act as a mechanism for prevention.

11: Developing recovery champions

The fundamental assumption of much of this work is that recovery is interpersonally driven and motivated. There is strong support for the fundamentally interpersonal transmission of recovery – Klein, Canaan and Whitecraft (1998) studied a peer support programme and found that those who received the services of a 'friend's connector' (peer recovery coach) had dramatically fewer crises and hospitalisations, less alcohol and drug use, improved living arrangements, better income and enhanced health compared to those who did not receive any recovery coaching support. Ryan et al (2006) found that the use of recovery coaches to help integrate addiction treatment and child welfare services for parents in substance –using families enhanced access to treatment and resulted in improved rates of family re-unification.

The United Nations Office on Drugs and Crime (UNODC) have reported on 'Sustained Recovery Management' (UNODC, 2008) and included an evaluation of a recovery coaching and personal recovery planning project in Illinois. They found that recovery coaches typically had just over one hour of contact per month and the evaluation involved 73 women assessed over a 5-month window reporting that while 4% were working at baseline this increased to 57% of those who were able to work by the follow-up point; 71% of participants had seen an improvement in their living situation and 26% had enrolled in further education. The recovery coaches were also successful at linking the women into health services and provided important family advocacy support.

More widely, when Blondell and colleagues (2001) compared the outcomes for hospital patients randomly assigned to 'care as usual', a physician delivered brief intervention or a meeting with a recovering (AA) volunteer, the people receiving the peer intervention superior outcomes at 6 month follow-up (64% abstinence compared to 36% and 51% in the other conditions in the study) had much higher rates of ongoing involvement in peer recovery support groups. The authors also concluded that visits by AA volunteers to hospitalised patients were simple, practical, involved almost no costs and posed little risk to the patients.

The volunteer also benefits from their involvement in peer support. Thoits and Hewitt (2001) reported enhancements in physical health, confidence, self-worth and life satisfaction, as well as reductions in depression and anxiety in individuals who volunteered to work with people in recovery. Thus, voluntary activity will not only result in improved wellbeing and outcomes for those receiving the intervention it will also provide an ongoing protective effect for those delivering peer-based support services.

In the UK the role of the recovery champion is being piloted in a range of innovation projects and is based on the idea of developing recovery capital and community-based networks of recovery support. What is apparent is that very rarely do individuals achieve sustained recovery without support from peers and mentors – across the UK 'end of careers' studies, the Glasgow and Birmingham recovery study and the long-term drinkers in recovery study (Best

et al, 2007; Best et al, 2010; Hibbert and Best, 2010), there are a total of around 850 recovery stories which all involve individuals achieving recovery with guidance and support from one or more inspirational figures. While some of the accounts involve workers, it is usually workers who 'go the extra mile', but more often it is peers who are also in recovery who have inspired both the initiation and maintenance of recovery journeys. While there is a supportive evidence base around 12-step sponsors (Humphreys, 2004), the idea of a recovery champion is broader than that and will include three broad categories:

- **Strategic champions – individuals who are capable of articulating and implementing a vision of recovery across services and systems and whose energy and drive will ensure that the principles of recovery are disseminated and adhered to;**

- **Therapeutic champions – frontline workers across a range of specialist addiction services who are active champions of recovery both in terms of transmitting hope and belief to their clients, but who also are active carriers of the recovery philosophy among their professional peers;**

- **Community champions – while the majority of these individuals will be people established in their own recovery it will also include family members and members of the wider community who are motivated and inspired to support recovery activities and communities and to tackle stigma and discrimination.**

The idea that recovery is 'contagious' (White, 2010) is based on the evidence of burgeoning communities of recovery in which collective recovery capital generates hope, provides role modeling of recovery and inspires the aspiration, belief and support needed to enable recovery journeys.

Key points

Recovery is contagious.

Recovery is inter-personally driven and sustained.

Recovery champions are the active carriers of recovery in professional and substance using communities.

SECTION 4:
RECOVERY IN THE UK

12: Recovery in Glasgow

In 2009, funded by Glasgow Drug Action Team and Glasgow Addiction Services, a study was undertaken to recruit individuals in recovery from a lifetime dependence on heroin or alcohol, using multiple methods including snowball recruitment, engagement with aftercare and community groups and advertising in local newspapers. A total of 205 individuals were recruited to the study – 107 in recovery from alcohol problems and 98 in recovery from heroin problems.

One of the most striking findings was the proportion of participants who were enthusiastic to be developed and supported to become recovery advocates in their local communities. There were two strong predictors of improved quality of life functioning in the group:

- **Those who were engaged in more activities in their local communities had markedly higher life quality – this was measured as more days spent engaged in childcare, volunteering (including involvement in recovery groups), education, training, part-time and full-time employment;**
- **Those who spent more time with other individuals also in recovery also had better quality of life. While it did not matter how much time was spent with non-users or current users, there was a strong benefit associated with spending more time with other people in recovery.**

There were some differences between the drinkers and drug users in recovery as shown in **Table 1** below:

Table 1: Differences in recovery profiles in Glasgow between drinkers and drug users

	Alcohol recovery group (n=107)	Heroin recovery group (n=98)	T, sig
Total time dependent	15.7 years	10.8 years	4.70***
Age first dependent	24.8 years	21.2 years	3.34**
Age last dependent	40.9 years	32.6 years	7.25***
Periods in AA/NA	7.5	3.1	3.31**
Age of key turning point in career	39.3 years	30.9 years	5.74***
Age at start of recovery journey	40.9 years	32.8 years	6.69***

This means that heroin users in recovery had shorter average using careers and became substance dependent much earlier, had far less time on average in 12-step treatment and typically started recovering at around the age of 30, while it was around the age of 40 for former drinkers.

The former drinkers had a more established history of working full time and a longer average period of being married as well as having more children. There was no difference (for those who have been homeless) in the typical duration of their homelessness experience. The heroin recovery group had more time in prison and a typical earlier age of first arrest and first imprisonment than the alcohol recovery group.

Having more people in recovery in the social network was associated with better quality of life in terms both in terms of internal recovery capital and social capital. Having more people in recovery in the social network was also associated with lower depression and higher self-esteem. More meaningful activities were associated with less anxiety, depression and fewer physical health symptoms, as well as with better self-esteem and self-efficacy. In other words, engaging in meaningful activities and being supported by other people in recovery not only leads to better quality of life but also improves functioning and personal strength.

Qualitative findings

The study also yielded some important qualitative findings about recovery - recovery was seen as a qualitatively different state of being, compared with addiction. For some respondents, recovery was viewed as an end or a goal ('achievable'), and they spoke in terms of personal effort ('You can get it if you want it'). Another view of recovery was as a life-long, ongoing or daily process of dealing with addiction, which was always going to be part of the person's make-up. From this perspective, there was no end to recovery ('still in it till the day I die'). One respondent reported – 'my recovery is going to be a journey for the rest of my life and at the moment I see myself as being on a stable recovery journey'. This view of recovery as personal growth was expressed typically by those attending mutual aid groups. Alcohol respondents were more likely to attend these groups.

Many participants talked about 'hitting rock bottom', 'had had enough', 'sick of being sick', 'broken', 'lost everything', 'my life was a mess'. Some cited specific events such as overdose, being found wandering in street or assaulting their partner. Many talked of physical or mental health problems. A number felt they were dying, from physical effects or because they were suicidal, so recovery was 'do or die'.

Some ex-alcohol users cited their behaviour as 'appalling' and that they felt 'disgust with myself'. Other reasons to change was increasing health problems and the impact of their behaviour on others. On the other hand, many ex-heroin users talked about 'the lifestyle' as 'chaotic', 'couldn't trust anyone', 'not cut out for it', abusive relationships, involvement with crime, police and prison, fears for their safety and debt. For some, a friend's or relative's death was a turning-point, or a diagnosis of Hepatitis C infection. Some mentioned children being taken into care, or their fear of this happening. Some ex-heroin users cited their age or maturity in taking a decision that 'heroin wasn't going to be a part of my life'.

Key points

There was no difficulty in accessing people in recovery in either location who were in abstinent recovery.

Many of those wanted to be able to give something back but did not feel that they were able to do so – this is a form of collective recovery capital that is not utilised adequately.

Two key factors promoted recovery and positive quality of life – more time spent with peers in recovery and greater engagement in activities in the community

There were marked differences in the pathways to recovery for drinkers and drug users.

13: Being better than well in recovery

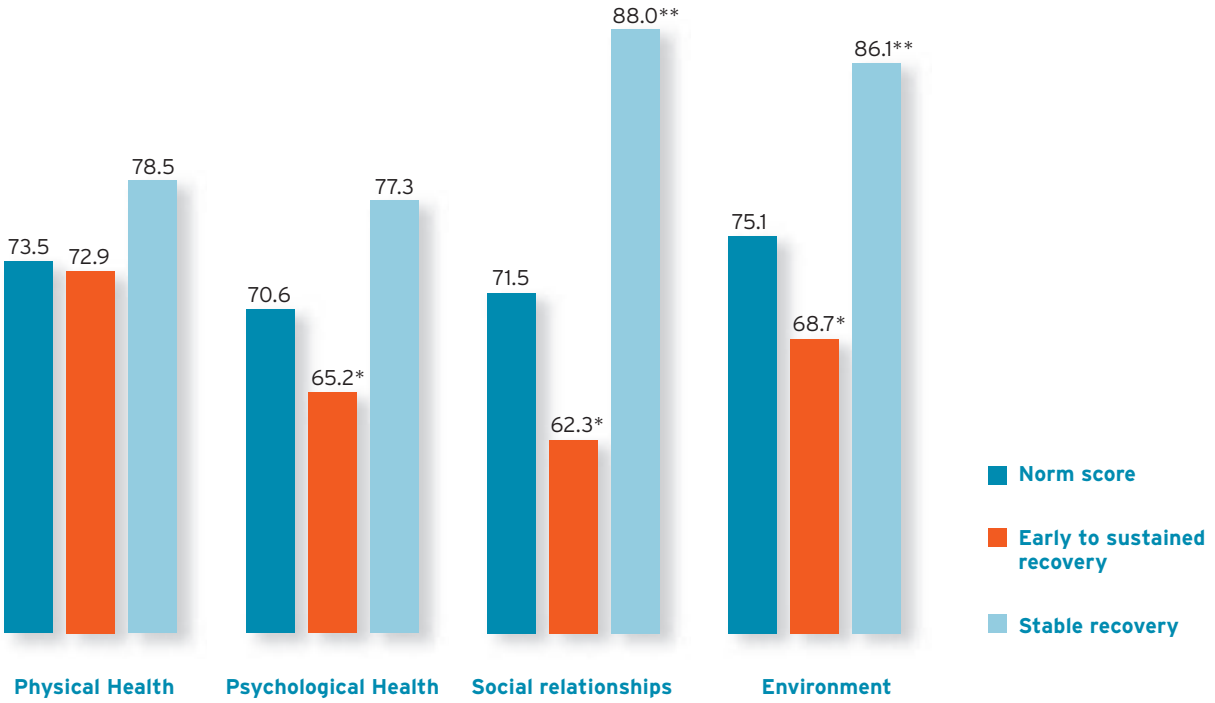
Hibbert and Best (2010): The aim of this study was to assess whether there were differences in quality of life between those in early recovery (less than five years) and those later into their alcohol recovery journeys, to test the assertion that stable recovery in dependent drinkers typically is achieved after five years abstinent. By using a standardised measure of quality of life, the authors wanted to show if elevated levels of quality of life were linked to the longest periods of time in active recovery.

Fifty-three recovering problem drinkers participated from mutual aid groups or snowball recruitment. Cross-sectional interviewer-administered structured questionnaires assessed quality of life (QoL), self-esteem, self-efficacy, psychological and physical health. Participants could also self-complete the questionnaire and return it by post. Fifty-three former problem drinkers participated. Five participants were less than a year abstinent but were approaching one year alcohol-free and expressed a desire to participate. These were grouped with 'sustained recovery' to form an 'early recovery' group. Recovery groups consisted of: 35 former drinkers in 'early recovery' and 18 in 'stable recovery'.

Those in 'stable recovery' (5 or more years into recovery, N=18) reported higher ratings of: three aspects of QoL - social relationships, psychological health, environment, as well as self-esteem than those in 'early to sustained recovery' (up to 5 years into recovery, N=35). Depression was lower in 'stable recovery'. Those in 'stable recovery' were more likely to live in their own home without professional support and have partners who had never been problem drinkers. Overall, the continuous scores of many functioning variables correlated with abstinence duration indicating a continuous gain in functioning rather than a stepwise change.

Crucially the study found that there were not only differences in quality of life between the people in early and later stages of alcohol recovery but that there were also higher rates of quality of life among those in stable recovery than the general public (who had never been alcohol dependent) in two dimensions – social life quality and satisfaction with the lived environment – as shown in **Figure 1** opposite:

Figure 1:
Differences in quality of life between early and stable recovery groups and the general public



*p<0.05 vs norm **p<0.001 vs norm

This suggests that long-term recovery was associated with being 'better than well'. As has been previously reported with populations in recovery from bereavement, those who achieve a sustained recovery have a 'gratitude' and humility that is associated with elevated levels of social and interpersonal sensitivity and awareness and greater satisfaction with their life.

A similar finding has also been reported by Valentine in Connecticut in relation to the quality of life of long-term heroin users. It suggests that, for those who achieve this level of recovery, it should not be regarded as overcoming a pathology but as a developmental and growth experience. In this conclusion, the recovery modelled here suggests a fundamental shift in paradigm from the assumption that recovery is about ridding an individual of an illness to a model that promotes long-terms wellbeing and growth. This is much more consistent with the definition of recovery developed by Deegan for mental health:

'recovery refers to the lived experience of people as they accept and overcome the challenge of disability... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability' (Deegan, 1998)

Key points

Quality of life continues to improve over periods exceeding five years in recovery.

For those who make it to this point in recovery, their wellbeing can exceed that typically reported by those never addicted.

This concept of 'better than well' offers a model of hope and change to populations and suggests that the goal of recovery is not a narrowly constrained model of symptom reduction but a quality of life process of ongoing growth.

14: Pathways to recovery

In 2007, Best and colleagues published the results of a survey which focused on achieving and sustaining abstinence. A total of 107 former problematic heroin users who had achieved long-term abstinence completed the survey. The cohort was recruited opportunistically from three sources, drawing heavily on former users working in the addictions field. On average, the group had heroin careers lasting for just under 10 years, punctuated by an average of 2.6 treatment episodes and 3.1 periods of abstinence. The most commonly expressed reason for finally achieving abstinence was 'tired of the lifestyle' followed by reasons relating to psychological health. In contrast, when asked to explain how abstinence was sustained, clients quoted both social network factors (moving away from drug using friends and support from non-using friends) and practical factors (accommodation and employment) as well as religious or spiritual factors.

This is consistent with international findings - Blomqvist (1999) reported data on a comparison of recovery in drug and alcohol users, finding that drug users typically had more pre-resolution negative events than alcohol misusers (particularly around legal and psychological factors) and that these strains persisted over the course of the recovery journey. Nonetheless, Blomqvist also noted that three-quarters of the sample reported at least some positive factors in their reasons to stop, such as finding a new partner. Blomqvist concluded that natural recovery was more likely to be associated with a combination of positive and negative motives, while treated recovery was more typically associated with hitting 'rock bottom'.

In comparing across substance using profiles, Best et al (in press) compared primary drinkers (n=98), primary heroin users (n=104) and those who reported problems with both alcohol and drugs (n=67). Former heroin users reported more rapid escalation to problematic use but much shorter careers involving daily use than was the case in the alcohol cohort. Alcohol and heroin users also differed in their self-reported reasons for stopping use, with drinkers more likely to report work and social reasons and drug users to report criminal justice factors. In sustaining abstinence, alcohol users more often reported partner support and drug users peer support and were also more likely to emphasise the need to move away from substance using friends than was the case for former drinkers. Users of both alcohol and heroin were least likely to cite partner factors in sustaining recovery, but were more likely to need to move away from using friends and to cite stable accommodation as crucial in sustaining abstinence.

But what is equally clear, and evident from the international work by Hser and colleagues (2007) is that, while there is evidence that would suggest that dependent alcoholics who achieve five years of stable abstinence are relatively safe from relapse, the course of recovery from opiates is far less predictable. The work by Dennis and colleagues (2007) shows that the risk is ongoing at least until eight years and that the proportion of those who will stably recover may be much smaller without a continuity of care and support.

This has significant implications for the establishment of recovery communities in Scotland. The fundamental building block of establishing predictable recovery is positive recovery capital and the hypothesis that is advanced here – based on the existing recovery evidence is that there are three types of recovery capital that will be needed to sustain a recovery journey:

- **Personal recovery capital** – the strongest evidence here is that this involves positive life and coping skills, self-esteem, self-efficacy and a positive (non-addict) identity;
- **Social recovery capital** – in the immediate sense this is the support of family and/or friends who will provide the resources and emotional and practical input to enable the person in recovery to cope with the demands of the recovery journey;
- **Collective or 'community' recovery capital** – this is both the identifiable resources available in the community in the form of visible and accessible recovery champions and the recovery support groups such as mutual aid and vocational support available in the community. However, collective recovery capital will also include the levels of discrimination and stigma and the impact recovery groups have had in addressing this.

Overall, the developmental model would suggest that there will be naturally occurring turning points in a life trajectory that arise from relationships, accommodation changes, jobs, and so on. The recovery and development model would suggest that the pathway to recovery will be the sum of recovery capital in all three manifestations available to a person when windows of opportunity for change arise and the extent to which these resources are sustainable over the course of the recovery journey.

Key points

Alcohol recovery journeys typically last for around 5 years, and heroin journeys typically for longer and may be more fragile.

What will determine the effectiveness of the individual recovery journey is the level and sustainability of recovery capital.

This is both personal recovery and social support embedded within a wider environment of collective recovery capital.

15: Where are the gaps in the evidence base in Scotland?

The evidence base review for 'The Road to Recovery' Scottish Government strategy (Best et al, 2010) highlights areas where the evidence base is strong. The review also suggests areas that require urgent attention to help develop a robust and coherent model for addictions in Scotland. These areas are listed in the following sections.

Treatment effectiveness

The success outlined above of abstinence-oriented treatments in the English National Treatment Outcome Research Study (NTORS), which showed that just under half of those accessing abstinence-oriented treatment were free from all opiates two years later did not provide sufficient differentiation between types of provision or in what the vital elements of success have been. In Scotland, the success of the Government's pilot of a quasi-residential provision, the Lothians and Edinburgh Abstinence Project (LEAP: Figure8 Consultancy, 2010), also suggests the benefits of abstinence oriented treatment, but needs further testing in a wider array of settings. Among the key questions that arise are:

- **The relative effectiveness of residential and community rehabilitation services (particularly as a large number of the latter have emerged in Scotland in recent years), in engaging and retaining clients;**
- **The focus on community rehabilitation would also address questions of the extent to which community rehabilitation provision successfully generates and initiates collective recovery capital in those communities;**
- **The extent to which 'Recovery-Oriented Methadone Maintenance' (White and Torres, 2010) exists in Scotland – this will involve assessments of two areas – first, the maintenance services that show the characteristics of recovery groups and communities; and second, the proportion of maintained clients who can be described as 'high-functioning' in terms of their independent living, community integration, effective parenting and employment status;**
- **How to create recovery oriented treatment services based on workforce development and culture change processes to ensure effective linkage and joint working between acute care providers and recovery systems;**
- **How acute treatment services can be supplemented by effective engagement and linkage with community groups including mutual aid;**
- **To develop an adequate science of 'aftercare' including the links between addiction recovery, housing and employment, training and education.**

Pathways to recovery

The key question here is about the role of personal, social and community recovery capital that is required to predict early engagement with recovery process and the successful maintenance of a recovery journey. Among the key research questions in this area are:

- **What is the rate of natural recovery in Scotland and what factors are associated with long-term recovery outside of treatment?**
- **What key life changes are associated with initiation of recovery journeys and what community and social supports are needed to enable long-term change?**
- **What are the role of mutual aid groups in recovery, not only AA, but also assessing the impact of NA, CA, SMART and other local recovery groups?**
- **How much do pathways to recovery vary by the profile of substance misuse, personal characteristics (such as gender and ethnicity) and by severity and complexity of life problems?**
- **Are there optimum ages for initiating recovery journeys?**

Number of people in recovery

There is a basic assessment needed on the prevalence of recovery in Scotland, initially to be assessed by multiple methods of data collection. This would provide a basic starting point for measuring the characteristics of those in recovery but this would also be a significant contributor to identifying how to enable recovery champions to be identified and supported.

Recovery communities

One of the most important transitions to a recovery model is the recognition that recovery happens in communities and is motivated and sustained by other people in recovery. There are a number of key questions that need to be answered in this respect:

- **Scotland already has a huge array of innovative local recovery groups and communities. Can we develop a method and commitment to evaluate these groups and to learn lessons about what works in recovery?**
- **Can we find evidence for 'recovery contagion'?**
- **Who are the carriers of recovery and what are the shared characteristics of recovery champions?**
- **What role do workers and services have in the development of recovery communities?**
- **How can diverse recovery groups and resources be supported and sustained?**

Overall, there is a growing body of recovery evidence in the addictions field that is supplemented by growing awareness of recovery process and practice from such diverse fields as mental health, criminology (where the idea of desistance is similar to ideas of recovery), community development and learning disabilities. Our science will not mirror that of addiction treatment but will complement and enhance it. In Scotland we are at the heart of a movement that characterises hope, opportunity and choice. It is essential that we develop the evidence base that will acknowledge and sustain this movement.

David Best
31.10.10

KEY CONTACTS AND ORGANISATIONS

The Scottish Drugs Recovery Consortium is a national membership organisation established to drive and promote recovery for individuals, family members and communities affected by drug problems and addiction. We are an independent charitable organisation working in partnership with the Scottish Government to support implementation of the national drugs strategy.

Scottish Drugs Recovery Consortium
234 West George Street
Glasgow
G2 4PQ
0141 226 1662
www.sdrconsortium.org
A full list of references for this document
will be available from our website.

Scottish Recovery Network
Baltic Chambers
320-323
50 Wellington Street
Glasgow
G2 6HJ
0141 240 7790
www.scottishrecovery.net

Useful Websites

Recovery Academy
www.recoveryacademy.org

Wired In
www.wiredin.org.uk

Faces and Voices of Recovery
www.facesandvoicesofrecovery.org

The Road to Recovery Strategy
www.scotland.gov.uk/Publications/2008/05/22161610/0

Research for Recovery: A Review of the Drugs Evidence Base
www.scotland.gov.uk/Topics/Research/by-topic/crime-and-justice/publications

Scottish Drugs Recovery Consortium, 234 West George Street, Glasgow G2 4QY
Telephone: 0141 226 1662 Fax: 0141 226 1663 www.sdrconsortium.org

Registered Office: 7 West George Street, Glasgow, G2 1BA Charity No SC041181 (Scotland)

SCOTTISH
DRUGS
RECOVERY
CONSORTIUM