

Recovery-oriented policy and care systems in the UK and USA

KEITH HUMPHREYS^{1,2} & ANNA LEMBKE²

¹Center for Innovation to Implementation, Veterans Affairs Palo Alto Health Care System, Menlo Park, USA, and
²Department of Psychiatry and Behavioural Sciences, Stanford University, Stanford, USA

Abstract

The concept of recovery has been an influence on addicted individuals for many decades. But only in the past 15 years has the concept had a purchase in the world of public policy. In the USA, federal and state officials have promulgated policies intended to foster 'recovery-oriented systems of care' and have ratified recovery-supportive laws and regulations. Though of more recent vintage and therefore less developed, recovery policy initiatives are also being implemented in the UK. The present paper describes recovery-oriented policy in both countries and highlights key evaluations of the recovery-oriented interventions. [Humphreys K, Lembke A. Recovery-oriented policy and care systems in the UK and USA. Drug Alcohol Rev 2013]

Key words: recovery, addiction, public policy.

Introduction

Recovery has been defined as an identity, health state and way of living that may be achieved by addicted individuals (detailed discussion of the definition and measurement of recovery is available elsewhere [1,2]). But at a different level of analysis, recovery is an inchoate set of public policy initiatives designed to create new services, re-envision existing care systems, adopt pro-recovery laws/regulations and disseminate pro-recovery cultural messages. After starting in the USA, pro-recovery policy currents spread to Scotland and then into the rest of the UK. This paper reviews these policy developments and evaluates whether the helping resources they support have evidence of effectiveness.

The history of recovery-oriented policy in the USA and UK

The first US federal policy built explicitly around the concept of recovery was the Recovering Community Support Program (RCSP), founded in 1998 during the Clinton administration. The US Substance Abuse and Mental Health Services Administration (SAMHSA) oversaw the RCSP, which gave grants over a four-year

period to 30 culturally, racially, geographically and philosophically diverse community organisations led by people in recovery and their families, allies and supporters [3]. The purpose of the grants was to empower recovering people to develop their own leadership capacity, to engage in public education about addiction and recovery, to advocate for higher-quality addiction treatment and to establish peer-designed and -led recovery support services that could serve as an adjunct or an alternative to the professional addiction treatment system.

The advocacy component of the original RCSP was somewhat controversial. As an institution, the US Congress has always been wary of the possibility that executive branch agencies (e.g. SAMHSA) would use monies appropriated them by Congress to advance their own political goals (e.g. that SAMHSA would give grants to community groups who in turn would pressure Congress to increase SAMHSA's budget). Fears of this sort motivated President George W. Bush's administration—which came to power in 2001—to restrict the activities of RCSP grantees to providing peer-based services (which was reflected in a program name change to the Recovering Community Services Program).

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Although it was never a large government program, RCSP did increase the capacity of a number of recovering community organisations to provide an array of peer-led services, to educate families about addiction and to pressure local treatment systems to become more responsive to their concerns [3]. The program also helped nurture a diverse cadre of leaders who became increasingly sophisticated in community organising and in interacting with treatment professionals, local officials and the media.

The Bush administration subsequently created a much larger (US\$99 million annually) 'Access to Recovery' program that provided vouchers for recovery support services to individual addicted individuals in the early stages of treatment. The vouchers could be used by treated individuals who had established initial sobriety. The vouchers could be exchanged for a range of services such as transportation to an Alcoholics Anonymous meeting or methadone clinic visit, job training, babysitting and peer counselling. The service provider could then redeem the voucher with the government for financial payment. Critically, a broad range of providers were allowed to provide the voucher-paid services, including many recovery community organisations. The policy thus not only supported people in recovery but also expanded the pool of available service providers.

In 2005, the federal government used its role as a convener of stature to hold a national summit on recovery in Washington, DC. The approximately 300 participants represented a wide range of pathways to recovery (e.g. methadone, 12-step, Christian faith-based, psychotherapy, SMART Recovery, Women for Sobriety), and special effort was placed on promoting dialogue among those varying groups regarding issues such as the definition of recovery, its guiding principles and the needed elements of a recovery-oriented system of care. Although it was not the official purpose of the summit, it had the added effect of allowing recovery movement leaders to make connections, share knowledge and set an advocacy agenda for the future.

Late in the Bush administration, SAMHSA created a new grant mechanism called Recovery-Oriented Systems of Care (ROSC). ROSC was even more ambitious than prior grant programs in that it was intended not just to add new services, but to fundamentally transform existing treatment systems into networks of support for recovery. Meanwhile, within the federal Veterans Health Administration, the largest provider of substance use disorder services in the USA, similar efforts were underway to change care in ways that paid greater heed to the wishes of addicted people and their families, focused on care-seekers' strengths rather than fixating solely on pathology, included peer counsellors

as partners and were responsive to the chronic nature of substance use problems [4].

The Obama administration, which began in January 2009, was the first to officially embrace recovery as a cornerstone of US drug policy [5]. The White House Office of National Drug Control Policy, commonly viewed as a source of demonisation of drug-addicted people, created an office on recovery and engaged in significant outreach to the recovering community regarding how to design effective drug policies. The Obama administration also engaged in many intentionally symbolic efforts to celebrate recovering people and simultaneously give hope to individuals still suffering from addiction, e.g. having the President's drug policy director march alongside recovering people at recovery celebrations, quoting leading recovery advocates in the President's National Drug Control Strategy [6] and in press releases, and having goodwill ambassadors for recovery affiliated with the office. Similar symbolic tactics had been successfully employed in prior eras to help destigmatise people with HIV/AIDS.

In addition to working alongside recovery advocates on key legislation, most notably the Affordable Care Act (which fully covers care for substance use disorders [5]), the Obama administration also tried to eliminate criminal penalties to which recovering people were subject, such as not being eligible for student loans because of a prior drug conviction. Although some of these efforts attracted significant support in Congress [7], at this writing such punitive laws sadly remain on the books.

The Obama administration also convened a national summit of recovery in 2010. The contrast between the 2005 and 2010 summits reflects the rising prominence of the recovery movement in the USA. The original summit had been arranged by the Center for Substance Abuse Treatment, a subcomponent of a small government agency (SAMHSA) far down the organisational chart of a cabinet agency. Five years later, the sequel was held at the White House and formally opened by a high-ranking representative of the President of the United States (Drug Policy Director R. Gil Kerlikowske).

The same year as the summit, the White House drug policy office also co-hosted a one-day think tank with the advocacy group Faces and Voices of Recovery regarding how peer-provided recovery support services could be reimbursed under the Affordable Care Act. This was the first time a recovery organisation had been a public, significant partner at such a high political level. Another first came in 2012 when a person in recovery was appointed by President Obama as the second highest-ranking drug policy official in the USA.

Though recovery-oriented policy has the longest history in the USA, it became a feature of policy in

Scotland [8,9] and then the rest of the UK [10] in the late 2000s. The genesis of recovery policy in the UK seems to have been pre-existing domestic dissatisfaction with some aspects of existing services for addicted individuals combined with increasing contact with USA-based recovery advocates who offered alternative ideas and new energy regarding service design [11].

The first UK policy action to fund recovery per se was probably the awarding of a grant from the National Treatment Agency for Substance Misuse (NTA) to expand the SMART Recovery organisation in 2008. Using local champions at six sites across England to begin SMART Recovery groups, educate treatment programs about SMART Recovery and build referral streams from the treatment and general populations, the project successfully grew the size and profile of SMART Recovery [12]. That said, in the UK, most recovery policy has been more symbolic, with recovery adopted as the guiding goal of Scottish drug policy in 2008 and subsequently being highlighted in key drug and alcohol policy documents from the Home Office (which has authority over England and Wales) and in an evidentiary review commissioned by the Scottish Government [13]. There has yet to be a parallel to the US policy of regularly providing significant grants to foster recovery organisations. However, recently (March 2013) the first UK Recovery Festival was co-organised by the voluntary sector in alliance with government officials, with a particular focus on demonstrating to employers the capacities of individuals in recovery to hold jobs [14].

The UK has established some supportive policy structures. Within the Advisory Committee on the Misuse of Drugs in the Home Office, a committee on recovery has been created for the first time. There is also a 'Recovery Partnership' organised mainly by individuals who operate addiction treatment programs (some of whom are personally in recovery). The Partnership reports to the government's Inter-Ministerial Group on Drugs and has an expert committee chaired by David Burrowes, MP, a member of the House of Commons. The Partnership was the leading organiser of the 2013 Recovery Festival mentioned above. Finally, in a potentially important symbolic development, the Duchess of Cambridge (better known perhaps as Kate Middleton) has adopted addiction as one of her personal causes [15], and because of the extraordinary media following she has, her frequent events with people in recovery may be destigmatising over time.

The most concrete current UK government policy to which some funding is attached is an innovative payment-by-results trial that will reward treatment providers who help get addicted individuals into recovery. As most efforts to improve addiction treatment outcomes have failed, the government can be credited for

trying a new approach [16]. That said, the study is only being mounted in a small number of locations in the UK and it will be some time before evidence on its success or failure is available. Finally, the NTA [17] convened a large number of experts on opiate substitution services, recovery and science to examine whether methadone maintenance could adopt a stronger recovery orientation. The diverse groups were able to agree on a set of principles that were promulgated and may have some influence on clinical practice.

As a final note on policy in both the USA and UK, there is no consistent partisan pattern to the champions of recovery. In the USA, President Barack Obama is from the farther left of the two main US political parties, but recovery-promoting policy initiatives have attracted strong support from conservatives as well, both during the George W. Bush administration and after. In the UK, the Tory–LibDem coalition government have embraced recovery, but there are also influential champions outside the current government (e.g. Lord Brooke of Alverthorpe, a Labour peer, and Baroness Finlay of Llandaff, a cross-bench peer) as well as in Scottish National Party-dominated Scotland. Recovery organisations themselves tend not to hew to the political left or the right but to the interests of addicted individuals and their families.

A brief review of whether recovery-oriented interventions are effective

Recovery-oriented public policies only matter if the interventions they support are beneficial. We therefore now highlight evidence on the effectiveness of three common types of such intervention: recovery housing, programs that facilitate 12-step mutual help group engagement and programs that expand peer help within professionally staffed treatment programs.

Recovery housing

Recovery housing is operated by and for persons with substance use disorders, with an emphasis on peer-driven, abstinence-oriented recovery. Unlike in professional residential treatment centres, residents set the rules of the house, use personal funds to cover rent and other costs of living and generally set no limit on length of residency, that is, there is no predetermined 'length of treatment stay' after which people are 'discharged'.

A randomised controlled trial was conducted with 150 individuals to evaluate the effectiveness of one type of recovery residence, known as an Oxford House [18]. After discharge from substance use disorder inpatient treatment, individuals assigned to an Oxford House were compared on 24-month outcomes with usual-care (professional outpatient treatment, residential care or

self-help group) participants. The Oxford House condition led to higher rates of abstinence (65% vs. 31%), more than twice as much monthly earned income and one-third the rate of incarceration. Productivity and incarceration benefits amounted to a savings of up to approximately US\$9500 per year (adjusted to 2013 value) per Oxford House resident [18]. In addition, 30% of the women in Oxford Houses who had lost custody of their children due to addiction regained custody, versus 13% in usual care.

Non-experimental studies of recovery homes are less rigorous than the Oxford House clinical trial but report similarly positive outcomes for substance use (11% abstinence at baseline compared to 68% abstinence at 6 months), employment (up 10–20% at six months), arrests (down 80% at 6 months) and psychiatric symptoms (down 5–10% at six months) for recovery home residents [19]. Contrary to concerns that addicted individuals with comorbid psychopathology would have difficulty living and functioning effectively with peers in a self-run group living environment, Oxford House residents with severe psychiatric comorbidity do not differ in abstinence rates from residents with mild or no psychopathology [20].

Programs that facilitate 12-step mutual help group engagement

Twelve-step group affiliation facilitation strategies are the most studied type of recovery-oriented interventions [21,22]. The data are of two types: studies that look at active referral to Alcoholics Anonymous and other 12-step mutual help groups, which usually consist of connecting patients with 12-step volunteers; and studies that look at professionally operated 12-step-oriented treatment programs, for example programs in which professional counsellors teach the 12-steps or otherwise encourage 12-step group participation, versus other types of professional treatment. In addition to substance use, outcome measures have included health-care service utilisation and costs.

Several randomised studies have examined the effectiveness of an ‘intensive referral’ to 12-step groups. Intensive referral comprises not just handing over a list of meetings but also discussing in detail any concerns and questions about 12-step group participation and linking the addicted person to an experienced 12-step group member. Patients actively referred to Alcoholics Anonymous or other 12-step mutual help groups are more likely to attend more meetings as well as to ‘do service’, get a sponsor and become a sponsor [23–26]. Those receiving intensive, as opposed to routine, referral are also more likely to maintain abstinence [16].

Turning to professionally operated treatments based on 12-step principles, patients in such programs are

more likely to affiliate with 12-step mutual help groups at follow-up compared with those receiving other treatments [27–29]. In Project MATCH, those in 12-step facilitation counselling had similar substance use outcomes to those in cognitive-behavioural therapy and motivational enhancement therapy at 15-month follow-up (87% days abstinent) [29]. Quasi-experimental studies have shown better substance use outcomes in 12-step-oriented professional treatments than in other types of treatment [27,28]. Furthermore, professional treatments that actively introduce patients to mutual help groups and recovery concepts offer significant financial advantages, with cost-savings as high as 65% annually relative to treatment programs that do not make similar efforts [27,28]. These savings appear to result from individuals relying more on 12-step mutual help groups and less on treatment professionals to cope with everyday anxieties, receive emotional support and obtain social contact after the most involved stage of treatment has been completed.

Programs that expand peer help within professionally operated treatment

A randomised study comparing an entirely professionally led treatment program with one with 50% less staff but higher expectations of patient self-management, involvement and mutual support showed no difference in substance use outcomes by program, as well as superior social adjustment among patients who participated in the peer-led program [30]. Although this study did not include a formal cost analysis, the 50% smaller staff suggests significant savings were achieved.

A different randomised trial compared inpatient psychiatric hospital treatment for civilly committed psychiatric patients (many of whom had comorbid addictions) with residence in an unlocked consumer-run crisis residential home in which the day-to-day staff was mental health consumers. Those participants assigned to the consumer-managed home demonstrated greater improvement in measures of psychopathology and higher service satisfaction [31].

Several non-randomised interventions in patients hospitalised for alcohol detoxification and/or alcohol-related trauma have shown that peer counsellors visiting these patients in hospital to motivate recovery is more effective than similar interventions by physicians [32,33]. However, one randomised trial comparing 12-step facilitation by peer counsellors and physician-led motivation enhancement therapy showed no difference in drinking-related outcomes, but a higher likelihood in the motivation enhancement therapy group of pursuing subsequent in-patient treatment [34].

Other forms of recovery-oriented resources have not been subjected to randomised trials. These include recovery coaching, recovery schools and recovery community organisations. These and other emerging forms of recovery support services are discussed in more depth elsewhere [35,36]. For present purposes, it is sufficient to note that the foregoing summary of evidence covers those recovery-oriented interventions that have been evaluated rigorously, leaving significant work to be done in other areas.

Evaluations of individual recovery-oriented interventions, rigorous as they may be, do not prove that recovery policies can transform whole systems of care, as opposed to adding a few effective elements to them [37]. As one moves from the level of programs to the level of systems, evaluation becomes more challenging, regardless of whether one is studying a recovery initiative or any other. Although some encouraging initial before-and-after comparisons have been conducted with systems that have undergone recovery-oriented transformation [38], rigorous evaluation of the process at the system level remains an important goal for the future.

Conclusion

Recovery-oriented policies are most fully developed in the USA, with significant funding being devoted to support recovery community organisations and to transform treatment systems in a pro-recovery direction. Within the UK, policy is at an earlier stage of development. Many of the interventions fostered by recovery-oriented policies have not been evaluated, and doing so should be a major priority for future research. That said, in areas where rigorous research exists it indicates that recovery-oriented interventions improve individuals' substance use and health outcomes in a cost-effective fashion, supporting the value of recovery-oriented public policy initiatives.

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Conflict of interest

Dr Humphreys served as an advisor or implementer on many of the US and UK policies described in this paper.

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