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The recovery paradigm

A model of hope and change for alcohol and drug addiction

Background

Alcohol and drug disorders remain major health and social problems in Australia, contributing enormously to the global burden of disease and the everyday practice of primary care. A recent growth in recovery research and recovery focused policies are starting to have an impact in Australia, with implications for how we attempt to resolve these problems.

Objective

In this article we discuss recent international findings in recovery research, and explore their implications for primary care.

Discussion

Research indicates that over half of dependent substance users will eventually achieve stable recovery. Key predictors of recovery are active engagement in the community and immersion in peer support groups and activities. Recovery requires a twin track approach: enabling and supporting individual recovery journeys, while creating environmental conditions that enable and support a 'social contagion' of recovery, in which recovery is transmitted through supportive social networks and dedicated recovery groups, such as mutual aid.

Keywords

substance related disorder; addiction; rehabilitation; models, theoretical

annual cost of addiction treatment per patient, a 46% increase in the number of people treated across the state, and a 62% reduction in hospital admissions among addicted groups.³ This suggests a recovery model may be a cost effective model for alcohol and other drug (AOD) treatment.

Background

In 1986, O'Brien and McLellan⁴ characterised addiction as a 'chronic, relapsing condition' and challenged the short term treatments that were routinely offered but frequently failed those with long term AOD problems. They argued that addiction was similar to diabetes or asthma in its duration and management, and that only offering short term detoxifications made relapse and the 'revolving door' of treatment a self fulfilling prophecy. Additional harms associated with providing short term treatments to address a chronic condition include the increasing physical and psychological morbidity related to ongoing substance use, the collateral damage to families and communities, and the growing stigmatisation of and discrimination toward those whose relapses are seen as a 'failure of will'. Indeed, clinicians who hold pessimistic and stereotyped views about their addicted patient's prognosis present a further barrier to delivering effective treatment.⁵

O'Brien and McLellan were not arguing that nobody gets better, only that the time course is protracted. In 2005, Dennis et al⁶ published longitudinal data from a sample recruited from a public treatment program in the United States suggesting that the average time from substance initiation to stable recovery is around 27 years. Likewise, in a prospective study of two community samples of adolescent males, Vaillant⁷ reported that by age 70 years, around two-thirds of once alcohol dependent men from deprived inner city backgrounds were abstinent (among those still alive). Addiction careers can therefore be

Although addiction is a disorder characterised by relapse and an extended time course, approximately 58% of addicted individuals will eventually achieve lasting recovery.¹ 'Recovery' has been defined in the mental health field as a process represented by the acronym CHIME – Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment.²

Recovery confers benefits to affected individuals, their families and local communities, and to society as a whole. This article draws on the successes achieved by the adoption of a recovery paradigm in mental health and assesses the potential benefits of a similar approach for alcohol and illicit drug treatment and policy. The adoption of recovery principles across the American state of Connecticut led to a 25% reduction in the

characterised by episodes of relapse, but with sustained change possible over long periods of time. Lessons from parallel fields offer further hope.

Recovery from mental illness and desistance from crime

Even among apparently intractable cases of mental illness, longitudinal research offers surprisingly encouraging results. Harding et al⁸ conducted a 32 year follow up study of the most difficult to place residents of a psychiatric inpatient facility with severe, enduring mental illness. At the final follow up assessment, 81% were able to look after themselves, 25% had fully recovered and 41% showed significant improvements while only 11% did not show any improvement and remained within the treatment and support system. More recently, Warner⁹ reviewed the evidence for recovery and reported, from over 100 studies, that 20% of people with schizophrenia 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. Long term treatments that focus on empowerment and community engagement may not produce cures, but can result in positive change in both quality of life and active participation in community living, including work and volunteering.

In 2011, Leamy and colleagues² published a systematic review that identified 97 relevant papers and identified five key recovery processes: connectedness, hope and optimism about the future, identity, meaning in life and empowerment. They identified 13 characteristics of the recovery journey: that it is an active process; an individual and unique process; a nonlinear process; that recovery is a journey; that recovery occurs in stages or phases; that recovery is a struggle; that it is a multidimensional process; that it is gradual; that recovery is a life changing experience; that people can recover without cure; that recovery is aided by a supportive and healing environment; that recovery can occur without professional involvement; and that it can be a trial and error process. These characteristics have considerable overlap with the AOD model outlined by Sheedy and Whitter,¹ presented in *Table 1*.

An equally important lesson comes from one long term study of recidivistic offenders. Laub

Table 1. Principles of recovery from alcohol and other drug treatment (AOD)¹

- There are many pathways to recovery
- 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 wellness
- 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 (re)joining and (re)building a life in the community
- Recovery is a reality

and Sampson¹⁰ completed the final phase of a 55 year follow up study of adolescent offenders recruited from a youth offending institution in Baltimore. Their interviews of the cohort at the age of 70 years (written up in the book *Shared Beginnings, Divergent Lives*) identified a small minority who continued to offend at the age of 70 years – the majority ended their criminal careers by their late 30s. The primary reasons for ceasing offending were stable employment, improvements in life, coping and social skills, attachment to a nonoffending spouse and changes in how they saw themselves. The authors concluded that 'the stronger the adult ties to work and family, the less crime and deviance among both delinquents and nondelinquent controls'.⁸ In other words, offending is not persistent across the life course, and for most offenders what enables them to 'recover' is adult responsibilities and the emergence of skills to sustain them.

What is recovery from substance abuse?

There have been two expert panel definitions constructed in recent years. In the United States, the Betty Ford Institute Consensus Panel¹¹ defined recovery as 'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship', and further differentiated stages of recovery by introducing the categories of 'early sobriety' (the first year), 'sustained sobriety' (1–5 years) and 'stable sobriety' (more than 5 years). The British 'vision' of recovery, developed by the United Kingdom Drug Policy Commission,¹² is characterised as 'voluntarily sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'. Both expert

groups emphasised individual variation in terms of timelines and pathways to recovery, with recognition that, in most cases, recovery is an ongoing journey rather than an accomplished state.

How often do people achieve recovery?

According to a review of international evidence conducted for the Centre for Substance Abuse Treatment 'epidemiologic studies show that, on average, 58% of individuals with chronic substance dependence achieve sustained recovery',¹ although rates varied from 30–72%. However, as Warner⁹ argued, for mental health, this may not mean full remission. Rather, it may involve transcending their symptoms to lead a meaningful and fulfilling life, including making a valuable contribution to family, community and society.

What is the evidence for recovery and long term change?

Despite a paucity of research, there is evidence supporting the notion of 'remission' from AOD problems. In a recent systematic review, Calabria and colleagues¹³ concluded that 'almost one-quarter of persons dependent on amphetamines, one in five dependent on cocaine, 15% of those dependent on heroin and one in 10 of those dependent on cannabis may remit from active drug dependence in a given year'.

In the UK, Hibbert and Best¹⁴ interviewed former alcoholics who had been abstinent for at least 1 year. Not only was there clear evidence of ongoing recovery growth, but those who were more than 5 years sober and in active recovery had better social quality of life scores

than the general public. This phenomenon has also been reported for long term drug recovery in Connecticut by Valentine,¹⁵ and is known as being ‘better than well’, as individuals transcend their addiction to play vibrant roles in their communities.

In a follow up study in Glasgow of 205 former alcoholics and heroin addicts in recovery,¹⁶ the strongest predictors of higher life quality were engaging in more activities (volunteering, education and training, work and family) and more time spent with other people in recovery. Likewise, in a sample of 354 recovering addicts in New York, gradual improvements in overall life satisfaction and reductions in stress ratings occurred over the first 3 years of abstinent recovery.¹⁷

One of the most important things we know about recovery is that other people matter. The resolution of severe alcohol and other drug problems is mediated by processes of social and cultural support.^{18–20} Both general and abstinence specific social support influence recovery outcomes, but abstinence specific support appears to be most critical to long term recovery.^{21,22}

In a randomised trial of alcoholics completing residential detoxification, participants underwent either ‘standard case management’ or ‘network support’ – with the aim of the latter being to add at least one sober person to the social network of the detoxed drinker.²² Relapse rates in the network support condition were 27% lower than in the standard treatment condition, emphasising the key role of peer support in enabling long term recovery, and the core underlying principle of ‘social contagion’. This is the idea, developed in the field of social epidemiology by Christakis and Fowler,²³ that complex social behaviours (including binge drinking and smoking) are transmitted via social networks through imitation and complex processes of social control and influence.

What are the implications for care and treatment?

As addiction careers typically exceed a quarter of a century, a range of interventions will be required at different times. It is crucial to support and engage those with long term AOD problems until they are ready to make lasting changes. This includes offering harm reduction approaches and evidence based interventions that

build therapeutic alliances and initiate change processes. There is no single strategy that will work for all patients and a recovery approach will only be suitable for those who are sufficiently stable and motivated, and who aspire to the CHIME principles as listed here.²

Additionally, taking lessons from the mental health recovery movement, we can infer that individuals can only make significant strides to lasting recovery if basic enablers are met. According to the mental health charity RETHINK,²⁴ for recovery to commence, individuals need:

- a safe place to live that is free from threat
- freedom from acute physical and psychiatric distress (including acute withdrawals and intense cravings)
- freedom to make choices and a clear sense of self determination, which requires both the provision of accurate information about what the options are and no limits placed on what is possible by professionals. In other words, this includes information about accessing educational and vocational courses, community support groups and other forms of professional supports, as well as clear messages about what they involve.

However, this is only the start of the recovery journey and ongoing support to achieve long term change and aspirational goals are crucial in helping people move beyond the initial stabilisation of symptoms to a more enduring set of life changes.

What does this mean for general practice?

Managing immediate physical and mental health issues, supporting housing applications and providing medications that stabilise the addiction (such as buprenorphine, methadone or anticraving agents naltrexone or acamprosate) are important first steps in assisting people to commence a recovery journey. Linking people into counselling and support services to help them deal with underlying poor coping skills, self esteem and self efficacy is a further step. But such interventions may not be enough in themselves, with the recovery model also requiring health professionals to:

- instil hope that the individual can recover and be mindful that their relationship can be a critical ‘turning point’ in the patient’s recovery journey

- act as a ‘bridge’ to groups and individuals who successfully model recovery
- involve family members in supporting their recovery journey.

Having a good understanding of the recovery support groups in your area (eg. Alcoholics Anonymous (AA), Narcotics Anonymous (NA), SMART recovery and other groups attached to local treatment services) and helping people to get to these groups is beneficial in reducing post-treatment substance use (*Table 2*).²⁵ Being active in this process increases the likelihood of effective linkages, and could involve your practice nurse taking patients to their first few recovery meetings or encouraging groups to actively recruit or hold meetings at your practice. Not all patients will be comfortable in a group setting, and for some individuals recovery guides and mentors are an essential preliminary stage. Building up the basic confidence and self esteem to benefit from group processes may be a necessary first step for many addicted AOD users.

While specific co-occurring disorders, such as brain injury or psychopathology, may have an adverse impact on such processes, attending mutual aid groups can benefit psychiatric symptoms as well as substance use.²⁶ Practitioners should discuss with patients that different support groups have different philosophies and dynamics, and they may need to try several different groups before they find one that is consistent with their own beliefs and whose members with whom they share common characteristics.

One final issue for consideration is around mapping the effectiveness of recovery-oriented interventions, and using feedback from changes in recovery functioning to support the patient’s journey. Clinicians may consider outcome monitoring tools such as the Treatment Outcome Profile,²⁷ a brief and validated measure that can be completed in around 5 minutes and measures recovery strengths as well as standard treatment outcomes domains for AOD use.

Recovery as a social movement

We have learnt in recent years that recovery does not happen in isolation and that recovery can have the strength of a social movement akin to the civil rights movement. In both the US²⁸ and the UK,²⁹

Table 2. Accessing key recovery support groups

Name	Purpose	Contact details
Alcoholics Anonymous (AA)	AA is a fellowship of men and women who share their experiences, strengths and hopes to solve common problems and help others to recover from alcoholism	For general information go to www.aa.org.au To find a local meeting, go to www.aa.org.au/findameeting/index.php
Narcotics Anonymous (NA)	NA is a nonprofit fellowship or society of men and women for whom drugs have become a major problem. Attendees identify themselves as recovering addicts who meet regularly to help each other stay clean	For general information go to www.na.org.au/community/index.php A meeting directory is available on this site
Alanon	Alanon Family Groups Australia aims to help families and friends of alcoholics recover from the effects of living with someone whose drinking is a problem	For general information go to www.al-anon.org/australia A meeting directory is available on this site
SMART Recovery	SMART Recovery offers face-to-face and online groups to people in the community who want and need help managing and overcoming addictive behaviours and their associated problems	For general information go to http://smartrecoveryaustralia.com.au To find a local meeting go to http://smartrecoveryaustralia.com.au/what-we-do/find-a-smart-meeting

the emergence of a visible social movement for change has inspired and enabled people who have recovered to come forward to act as guides and mentors to others in earlier stages of addiction. This process has gathered momentum and resulted in coordinated marches of thousands of people with the aim of celebrating recovery, challenging stigma and bringing together those from a wide range of motivations (people in stable recovery, people in early recovery, addiction professionals, general practitioners, family members and other members of the community) to convey the message that recovery is viable and sustainable. In Glasgow in September 2010 and in Cardiff in September 2011, more than 1500 people participated in recovery walks, which have had a role in changing the perceptions of the general public and the diverse array of participating health professionals and policy makers. This model of recovery has also drawn on an approach in public health, known as ‘asset based community development’,³⁰ in which the starting point for change is to map the assets and resources that can enable change at a local level. This would be physical assets (including

general practice surgeries), local community groups (including AA, NA and other support groups) and individuals (people who have managed their own recovery and who can support others). As a central component of local communities, GPs have a critical role to play in both starting and supporting personal recovery journeys and sustaining community change.

Conclusion

Although addiction is a chronic relapsing disorder most people recover, with flow-on benefits to both individuals and communities. Within the mental health field, adoption of a recovery model can bring about significant benefits for individuals and families, can inspire hope in communities and is a cost effective approach to delivering interventions. This approach readily lends itself to the treatment of addiction.

Key points

- The most recent review of recovery rates suggests that 58% of people with a lifetime addiction eventually recover.

- The typical time from first substance use to stable recovery is 27 years.
- What predicts recovery is exposure to recovery role models, and a sense of purpose and meaning.
- Recovery involves personal changes in both beliefs (about the attractiveness of reduced use, and abstinence where it is both desired and a realistic objective) and skills (coping skills, practical abilities), as well as social capital (friends modelling recovery and support for abstinence).
- Recovery is also a social movement where visible recovery champions can generate a social contagion of hope.

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