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EVIDENCE OF HOPE: WHAT DO WE KNOW ABOUT SUSTAINED RECOVERY FROM ALCOHOL AND DRUG ADDICTION?

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evidence of hope: what do we know about sustained recovery from alcohol and drug addiction?

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The paper to be presented today is about this recognition that most substance use treatment is not good enough and that treatment itself is not enough – it is not sufficient in its current form to support recovery, while recognising that recovery does happen and happens in community settings where indigenous resources provide the basis for the recovery journey.

1. THE POVERTY OF DRUG TREATMENT IN ENGLAND

This chapter reflects my own research career in the addictions field, and my experiences of addiction, but particularly NHS-run drug services and their impact on client recovery from addiction problems. I will start with some work I was involved in while based at the National Addiction Centre at the South London and Maudsley NHS Trust, then I will address some audits of drug services I led while working in Birmingham and then I will move on to talk about my more recent research work around recovery. However, this journey is more than a summary of research undertaken in three settings – it is about a transition from a mechanistic and pessimistic view of addiction and addicts – resulting in a pale shadow of what we could rightly expect treatment to be – to a vision of hope that is built on the recovery movement that is growing in the States and is beginning to find its feet – and more importantly its voice – in the UK.

I conducted several studies in the late 90's at a large on-site methadone dispensing service where many of the clients attended every day, and it was immediately transparent that neither workers nor clients really believed that what they were doing was 'therapeutic' – it was a controlled and negotiated relationship that revolved around access to free opiates, albeit an opioid that would not have been anyone's first choice. The clients showed little change over time, and for many, any change was a very gradual deterioration and reduction in quality of life and increased dependence on medication and on the maintained lifestyle. Yet the irony is that this population would indeed show reductions in offending, in injecting and in levels of illicit drug use – in other words, they would meet the targets of drug treatment pervasive in England today.

The first paper I was involved in at the National Addiction Centre (NAC) – "Time of day of methadone consumption and illicit heroin use: A study in two South London drug clinics" (Best et al, 1997) – was about clients timing their trips to the clinic for on-site dispensing to allow them to use heroin. Thus, the two dominant patterns in this group were early morning on-site methadone consumption to enable heroin use in the evening, often alongside other drugs, or late collection of methadone to allow heroin use in the last morning or early afternoon. In other words, it was assumed that the use of methadone would not be enough for many clients who would manipulate the daily on-site dispensing routine by using the flexible opening hours to 'use on top'. This is consistent with an oppositional model in which staff and clients are engaged in a 'game' of boundary testing and control.

The next year, I was involved in a

second paper "Eating too little, smoking and drinking too much: Wider lifestyle problems among methadone maintenance patients" (Best et al, 1998), which addressed issues familiar to critics of the 'social control' perspective of methadone. In this paper we identified a considerable proportion of clients who were daily, dependent drinkers, who had a lifestyle that revolved around the clinic. The notion of 'methadone, wine and welfare' is not a new one but this was a paper that was written from within one of the main prescribing centres in England and whose authorship included a psychiatrist who had championed methadone maintenance prescribing. The reason why this is possible is that it occurs within a model where expectations are so low that a certain amount of collateral damage is acceptable. It was, however, written before the advent of the crime reduction agenda in UK drug policy although its message – that there can be public health and safety gains while the individuals show no sign of 'getting better' has considerable relevance to the current debate about 'who benefits' from treatment.

2. TREATMENT EFFECTIVENESS

To some extent this is recognised in a policy response of which I was a part at the National Treatment Agency in London in 2005. There was growing unease at the quality of what was delivered as treatment leading to the launch of the Treatment Effectiveness Initiative in 2005, promoting manualised interventions in the hope that this would improve the baseline of psychosocial treatment and address the concern that what was happening was little more than 'medication plus'.

The development of treatment effectiveness built on a huge body of US outcome research evidence that is summarised in Simpson and Sells (1990) and then updated by Dwayne Simpson into what has become known as the Treatment Process Model. This is based on the recognition that while client factors are important, the effectiveness of formal treatment is massively influenced by factors around the worker and the service – indeed the proportion of outcome variance that is explained by service factors is much higher than individual client characteristics – see Figure 1 below. When we translated this work to Birmingham, what we found was that the core of good treatment was a strong therapeutic relationship and active client participation in treatment. Where this was better, clients were more motivated, were more satisfied and had higher self-esteem and self-efficacy. But this in turn

was related to how motivated and how satisfied the workers were. In other words, how clients felt about treatment often reflected the motivation and drive of the workers they were engaged with.

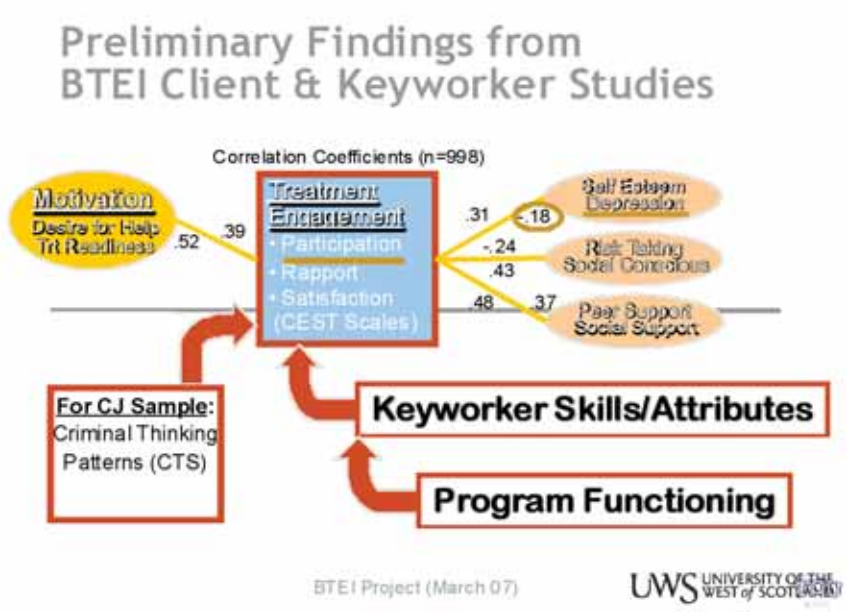


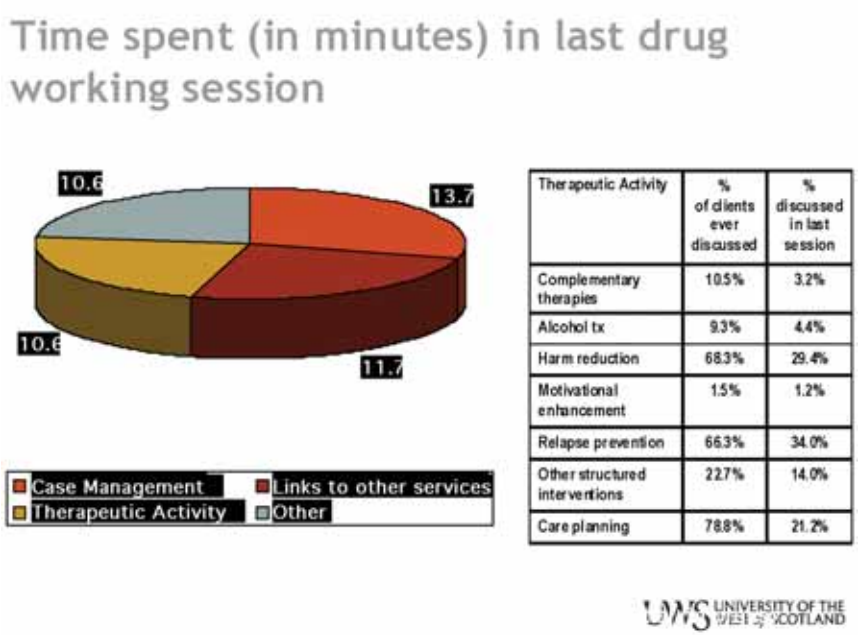
Figure 1: Relationship between worker and service characteristics and client outcomes

The major implication of this is that there is a powerful dynamic between how workers feel and how clients feel. If workers are not engaged in the process of treatment delivery, this creates a spiral of low expectations and dissatisfaction among clients.

3. WHAT DOES DRUG TREATMENT LOOK LIKE IN THE UK?

As a core part of rolling out the Treatment Effectiveness Initiative (NTA, 2005) in Birmingham, we conducted some basic work on what actually goes on in treatment sessions. The aim of this process was to improve the quality of delivery of psychosocial interventions in drug treatment and, to prepare for this initiative, Birmingham conducted an

audit of all specialist adult drug treatment services to assess what typically occurs in treatment sessions. Our findings (reported in Best et al, in press) were not encouraging – the majority of clients were seen fortnightly and were typically seen for around 45 minutes in each session. In other words, the total contact time per client is around 90 minutes per month, or 18 hours a year if the treatment lasts that long. However, it was our analysis of what that time consists of that is the greatest cause for concern, as is shown in Figure 2 below:



Therapeutic Activity	% of clients ever discussed	% discussed in last session
Complementary therapies	10.5%	3.2%
Alcohol tx	9.3%	4.4%
Harm reduction	68.3%	29.4%
Motivational enhancement	1.5%	1.2%
Relapse prevention	66.3%	34.0%
Other structured interventions	22.7%	14.0%
Care planning	78.8%	21.2%

Figure 2: What goes in drug treatment sessions

In the average session, the initial activities that were typically undertaken were case management activities around prescription management, drug testing and results, compliance and signposting. There was very little time available for, or commitment to, delivering evidence-based psychosocial interventions. In other words, what is called treatment, for the majority of clients on substitute prescribing is, in fact, 'a script and a chat'. When we looked in more detail at what goes on in one of the criminal justice teams (Best

et al, 2009), what we found was that workers are caught between the role of case managers and the role of therapists, and that it is the therapeutic identity that becomes secondary at time of considerable demands around risk management and clinical governance.

We have since repeated this work in a second partnership area in the West Midlands of England. Here we found that the average contact time, in drug and alcohol services run by the NHS, was 63 minutes per month. In this review of 753 clients currently engaged in treatment, clients averaged 5.4 contacts in the last 3 months, and the average session lasted 34.5 minutes. The service consisted of four teams with the average contact times among the drug teams being:

- Community drug team – 69 minutes
- Criminal justice – 68 minutes
- Shared care – 48 minute

So not only was there low levels of contact, this also did not seem to be differentiated by where the client was in their 'treatment journey'. This is prescribing and not treatment and, in effect, the prescription 'swamps' all of the other elements of the treatment process.

The problem is that this arises from the exceptionally low expectations that services have of outcomes. Most clients get caught in this model of safety first prescribing without end, and the 'therapeutic' part of the treatment is generally delivered by workers who do not believe that meaningful recovery is possible. This forms the basis for a downward spiral in which workers have low expectations of clients who expect only medication and management from services resulting in little therapeutic work and a mire of maintenance in which clients have little opportunity for change or progression.

Yet this is not justified by an analysis of the evidence base. According to the national drug treatment outcome study (NTORS, Gossop et al, 2001; Gossop et al, 2003), around one-third of admissions to Tier 4 services (either in-patient detoxification or residential rehabilitation) resulted in abstinence from all drugs at 2 years, and the same result occurred for around one quarter of community detoxifications. Indeed, if a lower threshold for success is used, 48.4% of the residential admissions were abstinent from all opiates two years after admission (as shown in Figure 3 opposite).

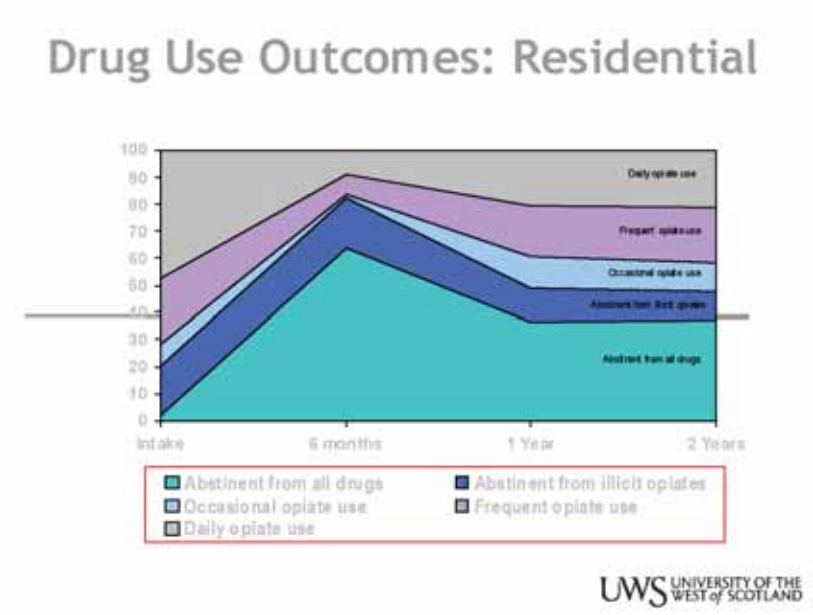


Figure 3: Changes in opiate use in the residential treatment population from the English National Treatment Outcome Research Study (NTORS)

Furthermore, the NTORS data would suggest that it is the same people who are abstinent at each time point, indicating a consistency of effect. In other words, just under half of all residential admissions in the National Treatment study were not using any opiates two years after starting their treatment and around one-third were not using any illicit drugs at all, with most of those having been abstinent for the entire post-treatment period.

Thus, while not all drug users will achieve abstinence the first or even the second time they try treatment, this does not mean that long-term abstinence is not a viable goal. In the DARP study (Simpson and Sells, 1990), the average length of the heroin career was 9.9 years for those who achieve abstinence, suggesting that heroin addiction careers are lengthy but that recovery is possible, albeit predicated on mediating variables such as the intensity of drug problems, the motivation of the users and the extent of supports (such as family and non-using friends) the individual has to support them during their recovery journey (White and Kurtz, 2006).

There is also a substantial literature on 'natural recovery' (eg Granfield and Cloud, 1996) suggesting that, for a group of problem users, recovery is achieved without recourse to formal addiction treatment services. For these individuals, the rejection of an 'addict' identity and changing the peer group to non-using friends were seen as key elements in recovery. The aim of the current report is to provide an account of the experiences of a group of former users who have achieved and sustained abstinence to assess their experiences of the 'recovery journey'.

4. A BRIEF DIVERSION – DEVELOPMENTAL MODELS IN CRIMINOLOGY

In 2004, John H Laub and Robert J Sampson published a book entitled "Shared Beginnings, Divergent Lives: Delinquent Boys to age 70" which is based on interviews with a cohort of 70 year old men who had been remanded to reform school in Boston in the 1940's. The key methodological approach is to take a 'life-course' or developmental perspective to assessing offending careers. Figure 4 below shows the trajectory of offending careers for this group of men

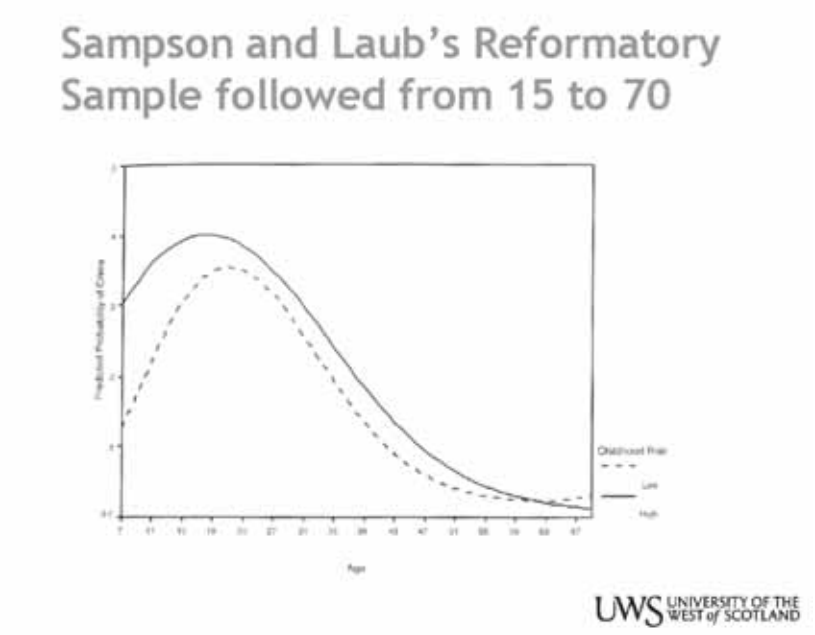


Figure 4: Crime careers of reformatory school boys followed to the age of 70

There are three main conclusions that derive from this work:

1. The vast majority of offenders 'mature out' of offending
2. The 'risk factors' that appear so potent in early years – poverty, poor schooling, early onset of substance use and offending, and so on – have little predictive power in mapping long-term offending trajectories
3. The two key predictors of long-term desistance from offending are getting a job the person is happy with and being in a relationship (with partner or whole family) that the person is comfortable with. "Treatment" or interventions were not strong predictors of positive outcomes.

Why is this relevant to a book about recovery from addiction problems? It is only an analogy – not all drug users are offenders and not all offenders and drug users, but nonetheless there are important lessons to learn. The first of these lessons is that we need to take a longer perspective if we want to understand whether people will 'grow out' of addiction problems – and to continue the parallel – most but not all will. The second point is that what will enable people to grow out of their addiction problems are to do with broader life issues not to do with short-term interventions. Thus, the implication is that, regardless of what 'treatment' can offer, it is a wider social movement towards building 'social capital' that is important in supporting people to sustain recovery journeys.

For Laub and Sampson (2004), the key 'desistance predictors' are:

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

Although we cannot assume the equivalence for substance users, we do relatively little to support or enable those factors, particularly given the findings of the UK studies reported above indicating what drug treatment means in practice for many people. This will also be reflected in the recovery research findings below about what our current evidence base suggests. And the big message from the Laub and Sampson findings is that there is hope for virtually all – no matter how entrenched people are, there are grounds for optimism and those grounds are predicated on naturally occurring life events – families and jobs, with treatment having a relatively peripheral role to play.

The notion of recovery as linked to social capital is also important in two senses. There is the traditional view of social capital as "The sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of

mutual acquaintance and recognition" (Bourdieu, 1992). However, there is also a second sense much more akin to a Hobbesian social contract in which social capital also manifests as the extent of the individual's commitment to social norms and processes. In other words, it is both an issue about the support systems that an individual has and about their desire to commit to conventional values around families, jobs and aspirations. Thus, within the model developed by Laub and Sampson, this may well involve maturational processes including ageing and a transformation of personal identity.

5. THE EVIDENCE FOR RECOVERY

Much of our understanding of recovery comes from two sources – studies of natural recovery and treatment outcome studies. To consider the natural recovery model first, it is important to bear in mind that for many substances, and in many settings this is the norm, and the notion of institutionalized treatment as a necessary component of recovery is alien. Perhaps the most obvious example of this is around smoking, but 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. In other words, for many people the way that they have achieved recovery is through their own volition and with strategies that do not necessitate formal treatment interventions.

Granfield and Cloud (2001) have suggested that "Those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment" (Granfield and Cloud, 2001), within this model that suggests that treatment is a slightly unusual way of addressing addiction problems and one that may be adopted by only a small (and not particularly representative) group of people who get into trouble with alcohol or drugs.

Even within the treatment population however, the evidence for positive outcomes for intensive, abstinence-oriented interventions is reasonably good, as reported in the NTORS data above. While the abstinence rates were lower in the Scottish treatment outcome study (DORIS, McKeganey et al, 2006), a similar conclusion was reached – if abstinence is the goal, then residential treatments are more likely to support this objective. From a developmental or careers model, this is not surprising. For a shift in a trajectory of drug use to be sustained, there is likely to have to be a 'turning point' (Hser et al, 2007) that

enables broad lifestyle change and does not simply address the immediate profile of physical symptoms.

6. THE US RECOVERY MOVEMENT

There are two important recovery movements that have emerged in the US specific to substance use. Recovery-oriented integrated systems (ROIS, DeLeon, 2007) has emerged out of the therapeutic community movement and is described elsewhere in this book. The second has been led by the phenomenal work of William White and his collaborators and colleagues and will be the focus of this section of the chapter. What this movement has done is to offer both hope and direction to the addictions field – a hope that is now tangible in the UK and, while it is being grasped by policy-makers, is a hope that is springing from a ground level, and is apparent in recovery communities across the UK.

In 2008, Alexandre Laudet summed this view up in an editorial in which she concluded that "Understanding recovery and identifying factors that promote or hinder it will require a number of paradigm shifts for addiction professionals, including moving from an acute care model to a chronic or long-term approach, and shifting the focus of research and service provision from symptoms to wellness". The inspiration of this model is to look to success and to celebrate and build on those who have done it and to utilise them as the key 'recovery capital' resources in both developing our understanding of addiction issues and in providing the right kinds of support. William White has claimed that

"Recovery involves three critical elements: 1) sobriety (abstinence from alcohol drugs and unprescribed drugs), 2) improvement in global health (physical, emotional, relational and ontological – life meaning and purpose) and 3) citizenship (positive participation in and contribution to community life)" William White (2009)

White has gone on to argue that a recovery model has a number of key features – that there is a recovery orientation rather than simply stabilisation, that the model is strengths based in that it focuses on individual strengths and on recovery capital rather than disease and disability, that recovery is more interpersonal than intra-personal, and that it is based on a set of core skills. These include the planning of recovery, linking natural and formal recovery support systems and the development of personal and family resources. The focus is on the present and the future not on causes or past experiences.

The core conclusions of this model are not that there is no place for what we have thought of as treatment, but its place is early in the treatment journey where the focus is rightly on the

physical well-being and symptom management components of recovery. What the recovery movement has taught us is that, while necessary, these are not sufficient and that recovery is much more socially located and embedded in a broader agenda of growth and development for individuals but also for their families and their communities.

7. THE EMERGING EVIDENCE BASE FOR RECOVERY IN THE UK

Our starting point for this research work was simple – i was struck that we knew so little about what factors allowed those who made it to abstinence to sustain it, and, consequently, at a service commissioning and a service delivery level, we offered so little support to those who reached this point (this early point) in their recovery journeys.

The initial steps of this programme of work have been stumbling and are beset with methodological issues and problems, that reflect the nature of what we are trying to do. The initial investigation involved distributing a simple, four-page questionnaire at a conference held in London largely attended by people in recovery. We then extended this by distributing the questionnaire at the reunion of a rehab unit in Scotland (Castle Craig) and including copies in the middle of a magazine. In traditional research methods terms, this is a sampling disaster and generates all kinds of questions of representativeness but something arose out of this work that was much more encouraging. The short questionnaire was basically anonymous, although a box was included asking people if they would be willing to contribute to follow-ups. The response to this was incredible – more than three-quarters of those who filled in the questionnaire provided details and, just as crucially, acted as advocates and sponsors of the project, getting friends to fill it in.

So what did we find? The first slice of the data Best et al (2008) focused on 107 former heroin users, the majority of whom were working in the addictions field at the time of the study. They were predominantly male and white, and they had been working for around seven years at the time of the study. When asked what enabled them to finally give up using heroin, the answer was most commonly about ‘having had enough’ – a gradual process of not wanting to live that life any more, but also involving an event – family or health related in many cases that finally gave them the impetus to make the initial change. However, the key finding from our study was that participants readily differentiated between the factors that allowed them to achieve abstinence and the factors that allowed them to sustain it. The most important factors in sustaining recovery were ‘moving away from substance using friends’, suitable accommodation, and support from non-using friends (see

Table 1 below). In other words, it was the development of a support network that allowed recovery to be sustained. The findings also suggested that engagement with NA was a common feature in many of the recovery journeys reported.

What enabled people to maintain abstinence?

	Not at all	A little	Quite a lot	A lot
Support from a partner	45.2%	20.0%	12.9%	21.9%
Support from friends	14.5%	21.1%	16.9%	47.6%
Moving away from drug using friends	16.1%	5.0%	18.0%	60.9%
Having a job	31.2%	17.8%	18.5%	32.5%
Having reasonable accommodation	10.3%	17.6%	26.1%	46.1%
Religious or spiritual beliefs	22.3%	11.4%	16.3%	50.0%

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Table 1: Factors associated with sustaining sobriety in a UK sample

This cohort study has continued to grow and a second paper has now been written (Best et al, submitted) and submitted for journal publication based on a larger cohort of 269 former heroin users and drinkers, split into based on three groups – 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 then to cite reasonable accommodation as crucial in sustaining abstinence.

There are two implications of this. The first is that it is further evidence of what little knowledge we have of recovery pathways and how they may vary. The evidence from the study is that different substance profiles may have different implications for recovery pathways and routes – and also for the likelihood that people will use either mutual aid groups or formal treatment services – but says little about what the effect of location, gender, ethnicity, age and other such factors might be on recovery pathways. It also says little about non-abstinent recovery. However, the key discovery was not a finding but about the conduct of the study – that it was a positive experience for both researchers and the participants and the sense that conducting recovery research was filling a real gap that made it feel much more like action research and participation.

This has inspired the current programme of research currently being rolled out in Birmingham and Glasgow, which has three aims:

1. To map out the support groups in each setting that support alcohol and heroin recovery journeys
2. To collate the experiences of recovery of people at different stages of the recovery journeys and their support needs at different stages
3. To assess the role that different interventions play in supporting recovery pathways at different stages of recovery journeys

Although it is too early to present many results for the study, there are some key points to make. The Birmingham study had a target of 100 drug users in recovery, and the method involved use of peer interviewers and no researchers. At the time of writing the sample stands at 141, the majority of whom (around three-quarters) have expressed interest in either becoming recovery coaches or advocates and/or in being trained to be peer research interviewers. The aim of both projects is also to assess the relationship between maintained and abstinent recovery. Similarly, in Glasgow, there has been enormous support for the project and again it will run on peer lines with users in recovery acting as the researchers and some taking on a more active role in the study management and development. As William White has argued, this is not traditional clinical research because the act of participating can be a part of the recovery journey and the research process is participative and celebratory. This work will shed light on some ‘hypotheses’ about recovery pathways

but its significance is much more likely to revolve around its charting of the optimism and drive that characterises recovery communities in the UK.

The preliminary data from this work look encouraging but one of the early findings – as shown in Figure 5 – is that differences in wellbeing factors – are already beginning to emerge between maintained and abstinent recovery populations. Thus, the participants in abstinent recovery reported much higher self-esteem and slightly higher self-efficacy than those in maintained recovery.

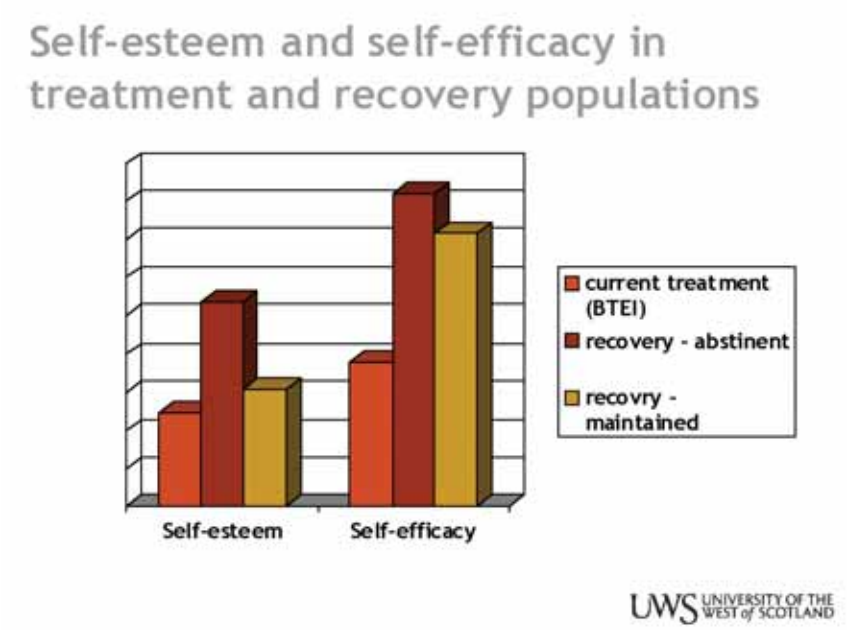


Figure 5: Self-esteem and self-efficacy in abstinent and maintained recovery populations

The final study worthy of mention was a medical student project carried out by Louise Hibbert. In this she attempted to access recovering drinkers in Birmingham, finally accessing a sample of 53 drinkers in recovery. She split her sample between early to sustained recovery (up to 5 years since last drink), and stable recovery (more than 5 years since last drink). Across a wide range of outcome indicators – such as physical and psychological health, self-esteem and self-efficacy, and social functioning, there was not only a group difference, there was a stepwise change so that clients reported typically better

functioning the longer it was since their last drink. However, Louise also found one crucial effect as shown in Figure 6 below.

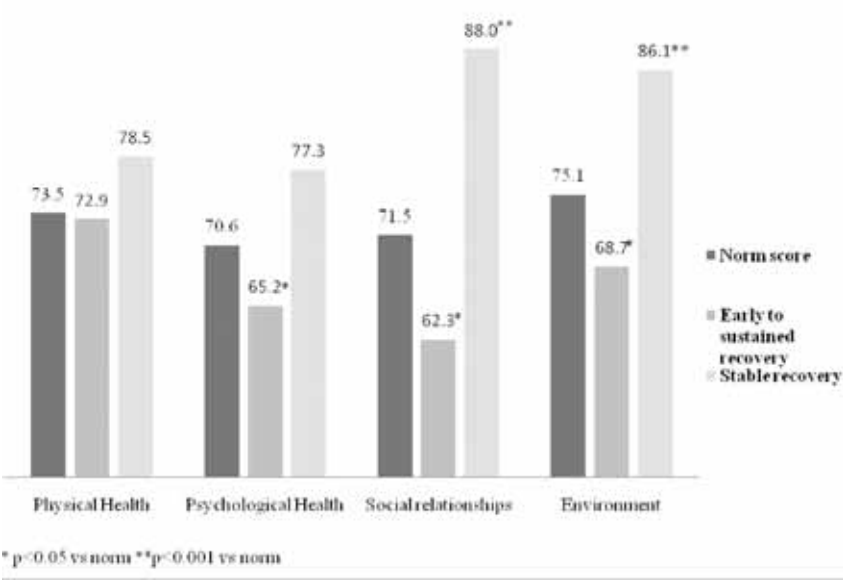


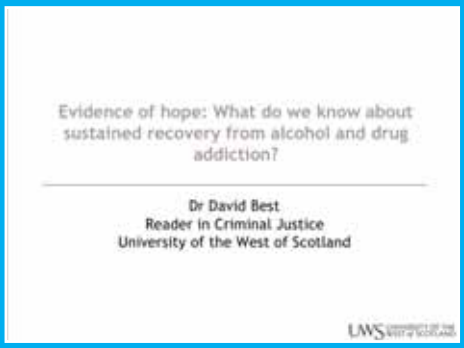
Figure 6: Quality of life in two recovered populations and the general population

What is remarkable about this finding is that not only do the stable recovery group exceed the early to sustained group in each measure they also report significantly higher quality of life around social relationships and their perception of their living environment than do the general population. In other words, prolonged recovery may well be associated with much more than just removal of symptoms, it may also generate more vibrant and positive life enhancements.

8. SO WHERE DOES THIS LEAVE US?

The recovery agenda creates a massive agenda for researchers. We not only need to do the basic work of mapping out pathways to recovery and developing 'developmental' models of addiction and recovery, we also need to couch this in a new language and in a new series of research methods. Our experience to date has been that there is a huge appetite among people in recovery not only to take part in this kind of research but to have a stake in it and to own the results. For this reason, we cannot pretend to a dispassionate observer status and we have to find academically credible ways of developing quantitative as well as qualitative approaches to action research that is owned by people in recovery. There is an increasing recognition in the UK that people do recover but we have little to say about how or when at the moment, and almost nothing to tell policymakers about what they can do (and what treatment services can do to help). We are riding on a wave of enthusiasm and optimism at present – it is essential that this is translated into meaningful change and evidence.

9. presentation



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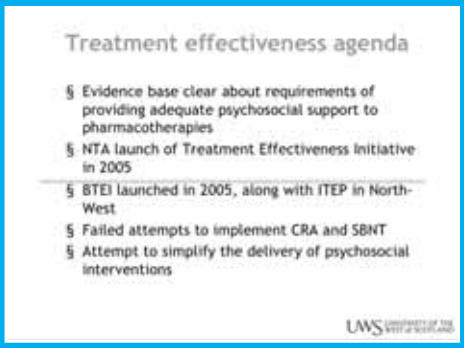

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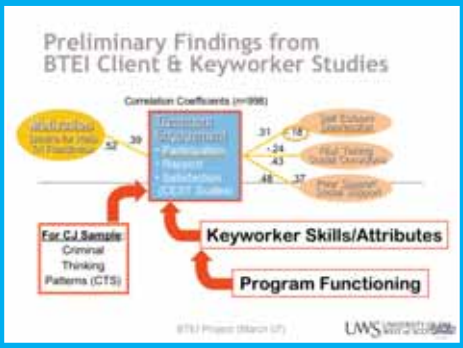

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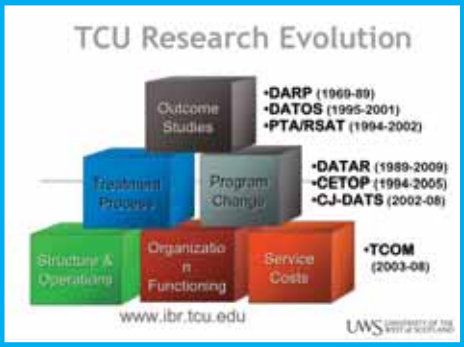

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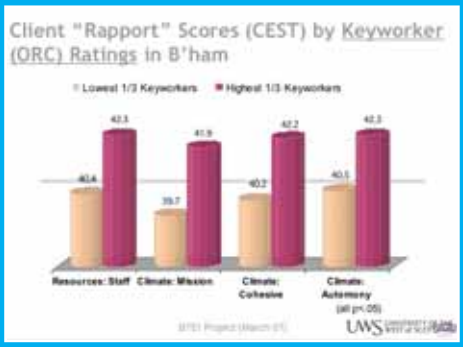

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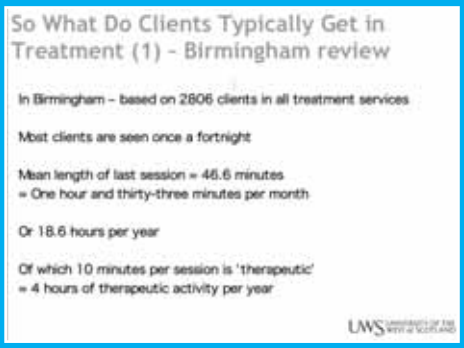

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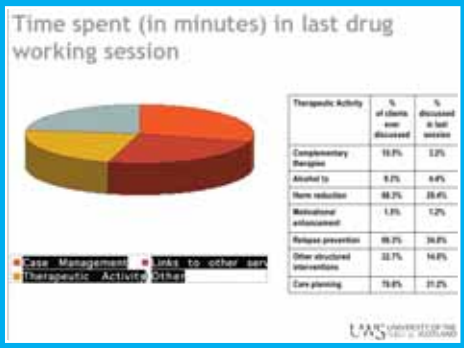

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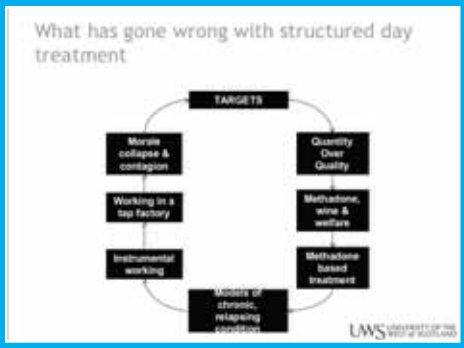

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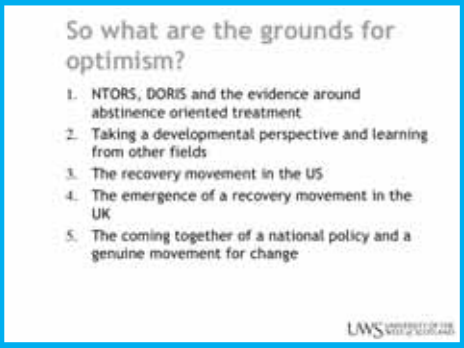

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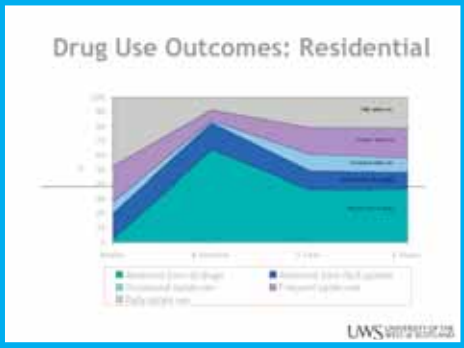

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What can we learn from the 'developmental' model of criminology

- § Laub and Sampson (2004) follow-up study of adolescents from youth offending institutes followed up to the age of 70
- § Key predictors of change were successful relationships and stable employment
- § Debate is about structure or function - what comes first?
- § Treatment can act as a turning point if it provides a window of opportunity for change, and there are available resources to sustain and support that change in real-life settings
- § White (2007): and the concept of recovery communities

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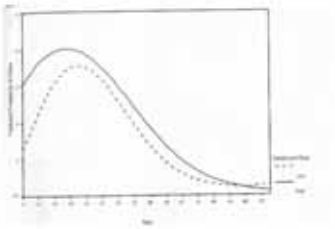
Sampson and Laub's Reformatory Sample followed from 15 to 70



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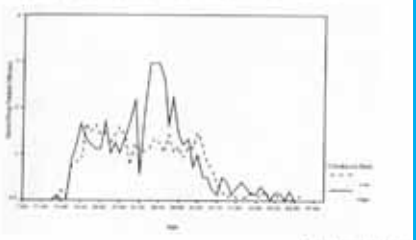
Sampson and Laub's Reformatory Sample followed from 15 to 70



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So what is unique about the careers perspective?

- § It is generally a model of hope
- § The Laub and Sampson model rejects a risk factors approach in favour of adult growth
- § While recognising the 'chronic and relapsing' nature of addiction, this is not seen as a life sentence
- § Key concept of 'turning points'
- § Windows of opportunity for change
- § The key turning points are psychological and social not biochemical
- § Links to White's concept of 'monocultural' and 'bicultural' social networks

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Social capital and the implications for treatment

"The sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (Bourdieu, 1992)

"Those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment" (Granfield and Cloud, 2001)

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Personal and social capital – linking psychological and sociological models

- § What are the resources at a person's disposal?
- § What is their stake and commitment to the conventional values of society
- § Laub and Sampson (2004) - desistance predictors
  - Attachment to a conventional person (spouse)
  - Stable employment
  - Transformation of personal identity
  - Ageing
  - Inter-personal skills
  - Life and coping skills

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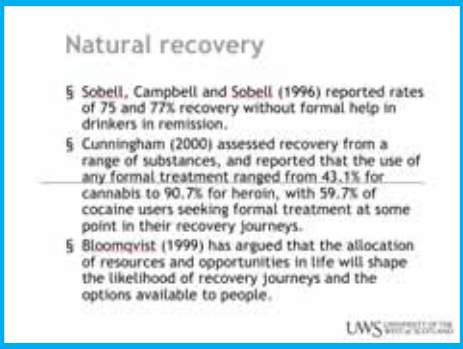

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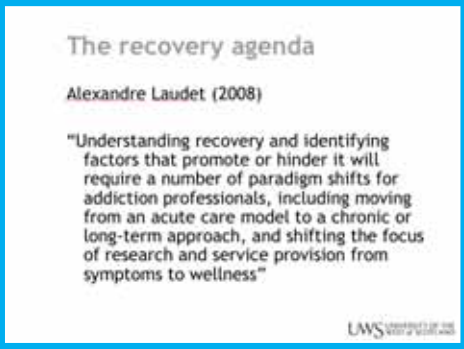

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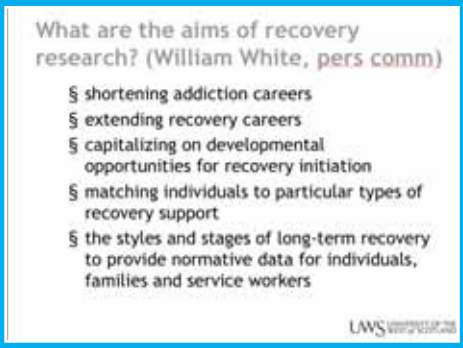

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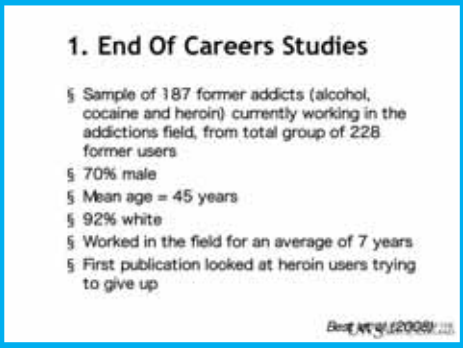

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	Not at all	A little	Quite a lot	A lot
Physical health problems	19.6%	42.4%	15.2%	22.8%
Psychological health problems	23.4%	18.1%	22.3%	36.2%
Criminal justice	30.4%	26.1%	19.6%	23.9%
Family pressures	36.0%	24.7%	21.3%	18.0%
Work opportunities	76.5%	9.4%	9.4%	4.7%
Support from partner	72.6%	15.5%	6.0%	6.0%
Help from friends	37.9%	28.7%	14.9%	18.4%
Tired of lifestyle	6.3%	4.2%	13.5%	76.0%

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What enabled people to maintain abstinence?

	Not at all	A little	Quite a lot	A lot
Support from a partner	45.2%	20.0%	12.9%	21.8%
Support from friends	14.5%	21.1%	16.8%	47.6%
Moving away from drug using friends	16.1%	5.0%	18.8%	60.9%
Having a job	31.2%	17.8%	18.5%	32.5%
Having reasonable accommodation	18.3%	17.6%	28.1%	46.1%
Religious or spiritual beliefs	22.3%	11.4%	16.3%	50.0%

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Comparison of drug and alcohol recovery journeys

- Compared primary drinkers (n=96), 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 then to cite reasonable accommodation as crucial in sustaining abstinence.

Best et al (submitted)

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Key qualitative themes

- Key role of social learning
- Need to complement recovery belief with recovery of esteem and learning of skills
- People may move through and beyond mutual aid groups
- Incompatibility of treatment and mutual aid pathways

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Preliminary Birmingham data

- Target was 100 participants in the study
- We have no researchers or paid staff on the project
- All data collected through a peer organisation
- At present, we have completed 141 peer interviews
- But running out of money
- Around 75% have requested training and support to become recovery advocates
- But where is maintained recovery?

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Preliminary Birmingham data

Mean age of first heroin use	19.4
Age of first injection	22.2 (n=12)
Total time heroin dependent	9.6 years
Age of last heroin use	30.9 years
Total time in methadone tx	5.1 years (n=18)
Age of last methadone tx	30.7
Perceived age at start of recovery journey	29.4 years

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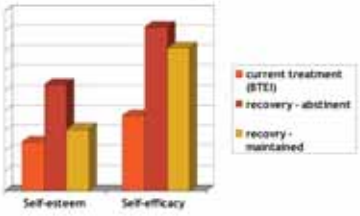
Self-esteem and self-efficacy in treatment and recovery populations



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Emerging qualitative themes

- § Reasons for stopping include a fear of rock bottom (losing everything), maturing out (tired of lifestyle) and family factors (pregnancy, loss of children and relationships)
- § Much support for 12 step, peer groups and day programmes
- § Frequent aspiration to become a worker in the field, and to be a better parent and person

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Mapping recovery in drinkers in early or stable recovery in Birmingham

Student project on recovery
(Louise Hibbert)

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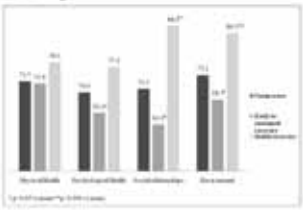
Mapping the recovery journeys of former drinkers in recovery



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Conclusion

- § Recovery research is better to do - and should be generally inclusive and participative
- § Recovery is about hope, and about self-determination
- § The addictions field - practitioners, researchers and policy makers - need this agenda to dig themselves out of the pit of despond and green sludge
- § This agenda is about de-medicalisation and de-professionalisation
- § Treatment is generally not very good, not very honest and is definitely not enough
- § The beneficiaries should be users, families and communities
- § As researchers we need to be humble about how little we know about recovery

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DR DAVID BEST

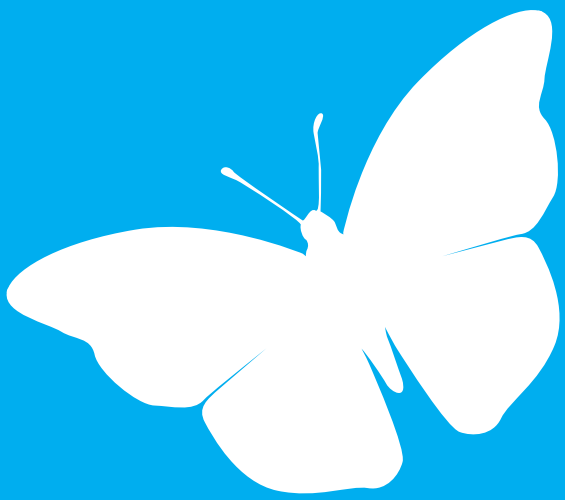
Reader in Criminal Justice at the University of the West of Scotland

Dr David Best is a Reader in Criminal Justice at the University of the West of Scotland, and research and development lead for Birmingham Drug and Alcohol Action Team. He is a Chartered Psychologist and a member of the British Criminological Society. He spent ten years working in research at the National Addiction Centre at the Institute of Psychiatry in London, managing a range of applied studies of drug and alcohol treatment, interventions to prevent drug-related deaths and drug-crime studies. He has also worked with the Police Complaints Authority, the National Treatment Agency and the Prime Minister's Delivery Unit. His current areas of research interest are around recovery journeys from addiction, the relationship between drug use and crime and the role of organisational functioning in influencing treatment effectiveness.

DR DAVID BEST

Darllenydd mewn Cyfiawnder Troseddol ym Mhrifysgol Gorllewin yr Alban

Mae Dr David Best yn Ddarllenydd mewn Cyfiawnder Troseddol ym Mhrifysgol Gorllewin yr Alban ac yn arweinydd mewn ymchwil a datblygiad ar ran Tîm Gweithredu ar Alcohol a Chyffuriau Birmingham. Mae yn Seiciatrydd Siartredig ac yn aelod o Gymdeithas Droseddol Prydain ac yn aelod o'r Gymdeithas Brydeinig. Treuliodd ddeng mlynedd fel ymchwilydd yn y Ganolfan Ddibyniaeth Genedlaethol yn yr Athrofa Seiciatreg yn Llundain, yn rheoli ystod o astudiaethau cymwysedig ar driniaeth chyffuriau ac alcohol, ymyrraeth i osgoi marwolaethau o achos chyffuriau ac astudiaethau i mewn i droseddau yn ymwneud â chyffuriau. Y mae wedi gweithio gydag Awdurdod Cwynion yr Heddlu, Asiantaeth Triniaeth Genedlaethol ac Adran Trosglwyddiad y Prif Weinidog. Mae ei feysydd ymchwil presennol yn ymwneud â gwellhad o ddibyniaeth, y berthynas rhwng defnydd o gyffuriau a throseddau a dylanwad gweithredu cyfundrefnol ar effeithiolrwydd triniaeth.



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