DOES TREATING PEOPLE INCREASE THEIR CHANCE FOR ABSTINENCE?

"Interventions geared for public-health and safety purposes can delay or prevent long-term recovery," find Dr David Best, Jessica Loaring, Safeena Ghufran and Ed Day. They advocate a 'life-course model' offering hope to client and clinician alike

LEARN FROM CRIMINAL "DESISTANCE".

In the field of academic criminology, growing attention is being paid to "developmental" models of offending behaviour, based on the rationale that successfully understanding offending patterns requires a life-span perspective.

Indeed, Thornberry *(2005, p156)* has argued that "the advent of developmental life-course theories of delinquency is perhaps the most important advance in theoretical criminology during the latter part of the 20th century".

The key factors to be understood are onset, course and "desistance" (quitting). Much of the evidence derives from longitudinal studies – ie, studying people over a long period of time.

One of the key works in this tradition was the longitudinal study by Sampson and Laub *(2003)* which followed a cohort of delinquent boys from teenage years to the age of 70. Having this kind of data enabled them to study one key component of the life-course model – desistance – in detail.

It led them to the conclusion that the key factors in predicting desistance from offending were commitment to both employment and to relationships.

They found that "the stronger the adult ties to work and family, the less crime and deviance among both delinquents and non-delinquent controls" *(Sampson and Laub 2005, p15)*.

The long-term outcomes from their study suggest that desistance is the eventual pattern for all men. But it is interesting to note that in discussing the model for desistance, planned interventions akin to treatment are afforded only a minor role.

This theme was picked up in a more recent study by LeBel, Burnett, Maruna and Bushway *(2008)* in their attempt to differentiate between 'subjective' and 'social' factors in criminal desistance. In essence, the challenge they addressed was whether work and stable relationships are symptoms of already-established changes in values and beliefs about offending, or whether getting married and/or finding suitable and stable employment act as catalysts for changes in beliefs about offending and commitment to mainstream values. Both positions accept the premise that changes in 'social capital' – the stake the offender has in conventional society – determine desistance from offending.

The authors concluded that both types of change are essential but that 'causal ordering' cannot be determined at this stage.

APPLYING THE MODEL TO RECOVERY JOURNEYS IN ADDICTION.

This provokes two questions for 'desistance from addictive behaviours'.

The first is if there are useful lessons from the 'life-course' model of offending, to improve our understanding of addiction. The second is if the 'criminological agnosticism' about treatment effects is justified for drug and alcohol addiction.

The evidence from our own work on end-of-addiction careers supports both of these suppositions in that:

- at least some addicts do come out of the other end of addictive problems, and they often cite factors in relation to employment and/or relationships, albeit after varying and apparently unpredictable durations of addiction careers
- from the 'end-of-careers' sample, relatively few of those who made a recovery journey cited treatment services as a part of the desistance process – if we do not include involvement in mutual-aid groups as part of the definition of 'treatment'.

The evidence from this is derived from the sum of two waves of data collection in the 'end-of-careers' study, which was supported by *Addiction Today* and by the National Treatment Agency for Substance Misuse.

A total of 269 individuals participated in either the initial phase or the follow-up phase of data collection, with participation restricted to those who were abstinent from alcohol, heroin and cocaine and who believed that they were stable in their abstinence.

The average age of the study population was just under 45 years, and the majority (71.4%) were male. In terms of their problem substance use, 104 (38.7%) had been users of heroin or cocaine only, 98 (36.4%) users of alcohol only and 67 (24.9%) had lifetime problems with both alcohol and illicit drugs.

Most of those who had taken part had some form of contact with drug or alcohol services, but the sample did include 31 people (12.0%) who had never accessed formal treatment as part of their recovery journeys.

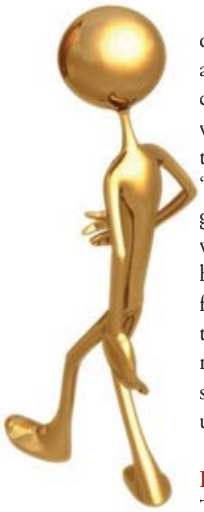
What is more striking is how rarely 'structured' treatment services are cited by former users as important contributory factors to their 'recovery journeys'. Indeed, when asked to contrast what had been different about the successful attempt compared to previous attempts to achieve abstinence, the most common reason given for previous 'failures' was poor professional support

in specialist treatment services. This constituted 29.2% of the answers to the question of "why had previous attempts been unsuccessful?".

FACTORS OF SUCCESS.

The only type of formal treatment service that was often cited as being among "the key things that finally helped you to *become* abstinent" was residential rehabilitation (16.9%).

In addition, mutual-aid groups were cited by 29.3% of the participants as a key factor in achieving abstinence and by 41.6% of those who offered an explanation for "what were the key things that enabled you to *stay* completely abstinent?".



In response to the latter question, only 7.8% indicated that any formal treatment input had contributed. This is compatible with residential rehabs regarding themselves as a unique-episode "kickstart" of clients into self-help group support. It suggests that, whatever its merits in reducing harm to health and public safety, formal long-term structured treatments played only a peripheral role in the recovery journeys of this sample, especially among the drug users involved in the study.

IS RELAPSE INEVITABLE?

The experiences of this population are at odds with the "chronic, relapsing condition" mantra which pervades UK drug services. They show that, at least for a proportion of illicit and polydrug users, sustainable abstinence is a viable objective.

Where the life-course perspective helps us is to understand that the time to achieve this can be extremely long and unpredictable. Yet this is not witnessed by most treatment services. What Gossop *(2008)* describes as the "clinical fallacy" is borne out here: that when people do succeed, they do so away from the clinic and so are not present to dispel the gloom-laden myth of chronicity, nor do many think to return – to clinics or GPs – to show that recovery has occurred.

It remains a moot point whether the chronicity philosophy, wedded in drug services to maintenance prescribing, actually acts as a barrier to recovery in individuals who otherwise would gradually move closer to sustained recovery. This is the price the individual drug user might be paying for society's gains in reduced disease and reduced offending.

SHIFTING LIVES FOR THE BETTER.

We come to the second question about whether treatment can act as a 'turning point', defined by Hser *(2007, p526)* as "responsible for major shifts in direction of life trajectories".

> *"It remains a moot point whether the chronicity philosophy, wedded in drug services to maintenance prescribing, actually acts as a barrier to recovery in people who otherwise would gradually move closer to sustained recovery"*

The answer from our sample appears to be according to how you define treatment. It seems that those treatments which focus on abstinence – rehabilitation and 12-step groups in particular – are reported by participants as turning points.

This is not meant to imply that the first meeting attended or the first episode of rehab automatically changes the trajectory of addiction careers. But it would appear that changes in psychological factors – belief systems, self-esteem, coping skills – deriving from or combined with the support of rehabilitation or mutual aid can act as a significant turning point in the addiction career and can act as a catalyst towards abstinence. What both of these forms of support have in common is ongoing assistance in the recovery journey.

SO WHERE DOES THIS LEAVE US?

In terms of developing an evidence base, it is still early days with this project. We are refining our questions and will increasingly look to recruit people who have either never been to any form of structured addiction support and those who have only ever been to 12-step groups, as we attempt to increase our understanding.

The sample that we have recruited to date can in no way be regarded as representative. But the consistency of the recovery journey stories we hear suggests that this represents a viable path to recovery. Our work should at least dispel the notion that, across all addicts, we are talking about a chronic condition with no end point. Conceptually and empirically, there are much stronger grounds for adopting a life-course perspective which offers hope to client and clinician alike.

To generate a more balanced perspective on recovery, it is crucial that more work is done in hearing the voices of those who have recovered, and in identifying what factors build the personal and social capital that enables sustained recovery.

It is also imperative that we seek to answer the question of whether formal treatments such as maintenance prescribing come at a cost – where long-term recovery is either delayed or prevented by interventions geared for public health and public safety purposes.

DR DAVID BEST is (bio to come...)

Images by Scott Maxwell