Mapping routes to recovery and the role of recovery groups and communities

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Research pathway

- "The myth of addiction" attributions and myths
- The Maudsley clinical research years – oppositional research
  - Best et al (1997) "Time of day of methadone consumption…"
  - Best et al (1998) "Eating too little, smoking and drinking too much: Wider lifestyle problems among methadone maintenance patients"
- Auditing what goes on in clinical service
- The re-emergence of hope – the developmental perspective and the recovery movement

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So What Do Clients Typically Get in Treatment (1) - Birmingham review

In Birmingham – based on 2806 clients in all treatment services

Most clients are seen once a fortnight

Mean length of last session = 46.6 minutes
= One hour and thirty-three minutes per month

Or 18.6 hours per year

Of which 10 minutes per session is 'therapeutic'
= 4 hours of therapeutic activity per year

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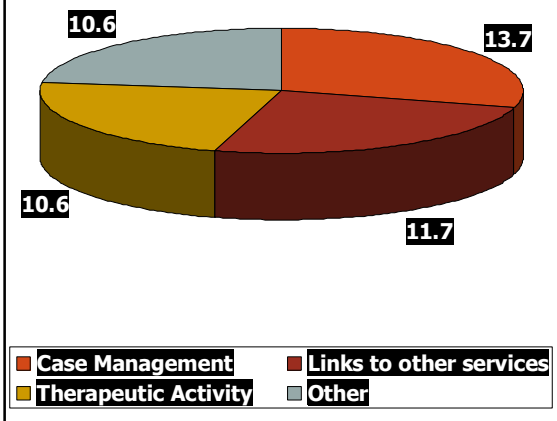
Time spent (in minutes) in last drug working session



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%

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Walsall service review

- Review of 753 clients
- Clients averaged 5.4 contacts in the last 3 months
- Average session lasted 34.5 minutes
- **Across all teams total contact time is 63 minutes per month**
- Amount of contact time per month was:
  - Community drug team – 69 minutes
  - Criminal justice – 68 minutes
  - Shared care – 48 minute

  Main problems were that services were not differentiated, clients dealt only with prescribing issues and nobody moved on - This is prescribing and not treatment

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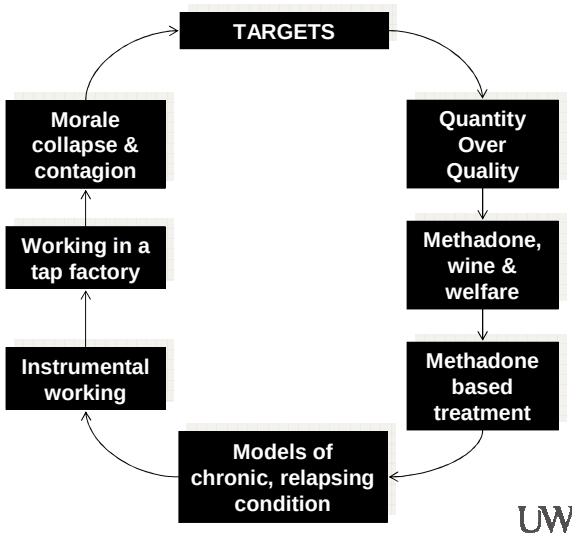
What has gone wrong with structured day treatment



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So what are the grounds for optimism?

1. NTORS, DORIS and the evidence around abstinence oriented treatment
2. Taking a developmental perspective and learning from other fields
3. The recovery movement in the US
4. The emergence of a recovery movement in the UK
5. The coming together of a national policy and a genuine movement for change

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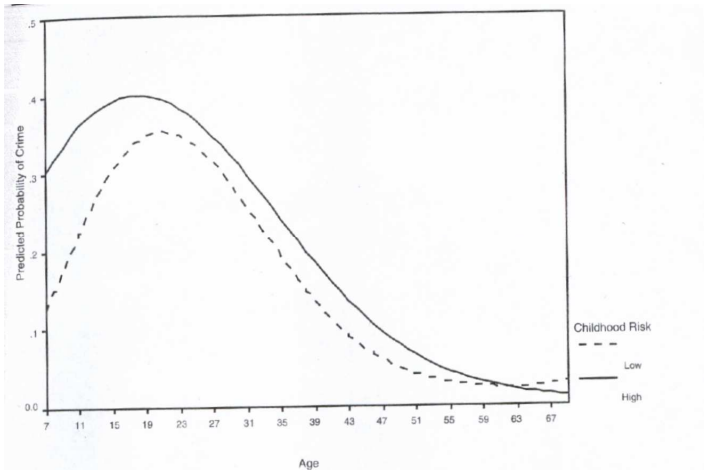
Sampson and Laub's Reformatory Sample followed from 15 to 70



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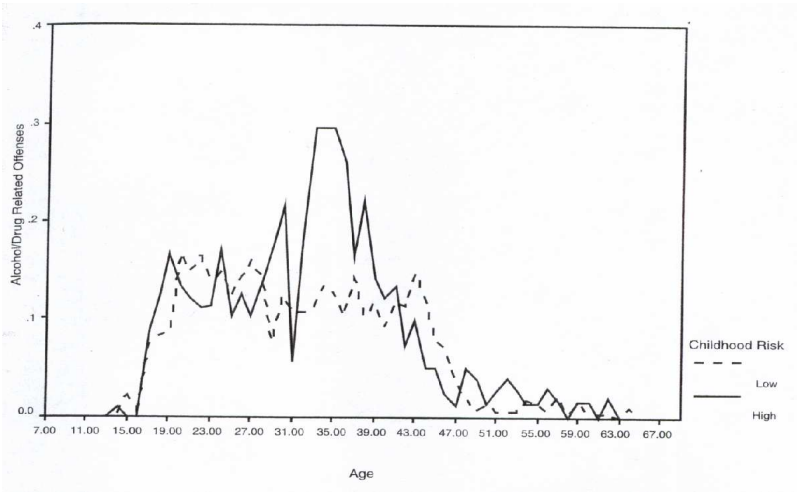

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So what is unique about the careers perspective?

- 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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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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The recovery agenda

Alexandre Laudet (2008)

"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"

What are the aims of recovery research? (William White, pers comm)

- shortening addiction careers
- extending recovery careers
- capitalizing on developmental opportunities for recovery initiation
- matching individuals to particular types of recovery support
- the styles and stages of long-term recovery to provide normative data for individuals, families and service workers

Key principles of the Road to Recovery

- Recovery is the explicit aim of all services
- A range of appropriate treatment and rehabilitation services should be available in each locale
- Treatment must integrate effectively with a wide range of generic servicees
- There is a commitment to establishing a Drug Recovery Network and to build the capacity of advocacy services

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So what is our own contribution to researching this?

1. The end of careers
2. Mapping recovery journeys and communities

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1. End Of Careers Studies

- Sample of 187 former addicts (alcohol, cocaine and heroin) currently working in the addictions field, from total group of 228 former users
- 70% male
- Mean age = 45 years
- 92% white
- Worked in the field for an average of 7 years
- First publication looked at heroin users trying to give up

Best et al (2008)

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What finally enabled participants to give up?

	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%	21.9%
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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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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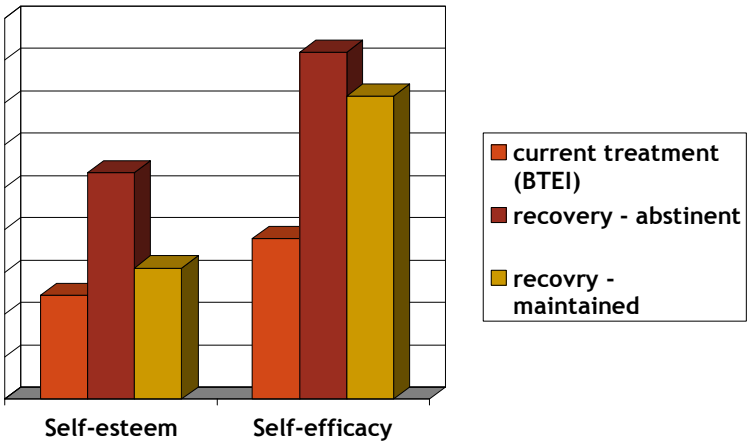
Self-esteem and self-efficacy in treatment and recovery populations



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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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