



Aligning Concepts, Practice and Contexts
to Promote Long-Term Recovery:

AN ACTION PLAN

RECOVERY
SYMPOSIUM
MAY 1-2, 2008

DOUBLETREE HOTEL
PHILADELPHIA
237 SOUTH BROAD ST.
PHILADELPHIA PA 19107

BUILDING THE SCIENCE OF RECOVERY

PRE-SYMPOSIUM BRIEF

April 2008

Alexandre Laudet, Ph.D.
Director, Center for the Study of Addictions and Recovery, National Development and Research
Institutes, Inc. (NDRI) laudet@ndri.org
<http://www.ndri.org/ctrs/cstar.html>

BUILDING THE SCIENCE OF RECOVERY

INTRODUCTION	1
WHY DO WE NEED A SCIENCE OF RECOVERY?	1
WHAT DO WE NEED TO KNOW?	2
WHAT WILL THE SCIENCE OF RECOVERY TELL US THAT WE DO NOT ALREADY KNOW?.....	3
CURRENT BARRIERS TO THE SCIENCE OF RECOVERY	4
FUTURE DIRECTIONS	5
APPENDIX: COMPILATION OF RECOVERY FOCUSED QUESTIONS.....	6
REFERENCE LIST	10

INTRODUCTION

In preparation for this symposium, the symposium planning group solicited input from various stakeholder groups about the types of questions we need to be able to answer to promote long-term recovery, inform recovery oriented systems of care (ROSC) and recovery management (RM), and minimize current barriers to recovery-oriented services. We obtained extensive input from the recovery community (based on the national work of Faces and Voices of Recovery in which the organization gathered questions and issues of concern to persons in recovery); surveyed service providers nationwide representing all treatment modalities and therapeutic orientations, funding source (public and private), agency size, and geography (urban and rural); and obtained input from the research community. The resulting feedback was then organized into broad categories that are presented in this brief (“What do we need to know?”). A more detailed list of topics and questions is presented in the Appendix.

This brief summarizes the need for and promise of the Science of Recovery, presents key research questions, and closes with a summary of current obstacles to conducting recovery-oriented research and suggestions for possible future directions.

WHY DO WE NEED A SCIENCE OF RECOVERY?

Decades of federally-funded research have resulted in a vast knowledge base about the nature (etiology, “causes”), patterns, consequences and treatment of addiction. Information on the prevalence of alcohol and drug use in the past month/year is easily accessible with a few mouse clicks, analyzable by age, gender, ethnicity, region and employment status. But there is much we do not know - **How many people in the US are in recovery? How did they get there?**

Treatment can be effective, especially with multiple episodes of care, but rates of reoccurrence are high even after several years. Less than one-third of people with drug or alcohol dependence ever seek treatment. **How do we “sell” treatment to those who need it?**

Medications that can help achieve (and maintain?) abstinence are currently available or in development and testing phases. The goal of these medications is primary symptom management. **ARE WE CURING ADDICTION?**

Addiction is best conceptualized as a chronic brain disorder. As such it cannot be cured but it can be managed. Comparing addiction to other chronic conditions such as diabetes, hypertension or asthma, McLellan noted the many similarities in the etiology, course, treatment and treatment outcomes across

chronic conditions.¹ However, more than (or perhaps unlike) any other chronic condition, active addiction has deleterious consequences on almost all areas of functioning (physical and mental health, family and social functioning, employment and education, housing, legal status, and overall well-being). Abstinence from drugs and alcohol is likely a prerequisite to improvement in other life domains, but it rarely brings instant relief.² Addicted individuals who address abstinence alone are unlikely to maintain that abstinence for a prolonged period. Individuals need to address “recovery” in the multiple life domains affected by active addiction. Moreover, unlike other chronic conditions, focusing only on the pathology of addiction leads to stigma which translates into discrimination against those who have overcome the disease and represents many obstacles to rebuilding lives – such as in housing, education, labor markets, etc. Many individuals emerge from active addiction with co-occurring mental or physical health conditions that also carry stigma (most notably HIV/AIDS). Many individuals who have overcome active addiction experience enduring shame and guilt about the impact their past substance use had on loved ones and on society. This may result in “spiritual malaise,” depression, and related negative emotions that can hinder recovery. These secondary symptoms of active addiction must be addressed as part of the recovery process. Would a diabetic experience relief from his/her condition by undertaking a “searching fearless moral inventory” (4th step)? Would a hypertensive consider the need to make amends (9th step) for actions taken when s/he was symptomatic? Yet, many individuals in recovery from addiction worldwide do so in the context of working the 12-step recovery program. **Thus, while addiction shares many characteristics with other chronic conditions, it also has a number of unique features that require attention when seeking to elucidate and promote stable remission (recovery).**

The World Health Organization defines health as “a resource for everyday life” rather than as the mere “absence of symptoms.”³ In an interview with Bill White, Dr. Clark recently stated that “Recovery is more than abstinence from alcohol and drugs; it is about building a full and productive life in the community. *Our treatment systems must reflect and help people achieve this broader understanding of recovery.*”⁴ The call is being heard. State by state, substance abuse services nationwide are undergoing a historic transformation from the prevalent acute care model to a person-centered, multi-system, continuum of WELLNESS-oriented care: recovery oriented systems of care (ROSC).

Though this is beginning to change (e.g., Betty Ford Institute),⁵ the construct of *recovery* has yet to be adequately defined, deconstructed, and operationalized. *Long-term recovery* is virtually uncharted territory. How can we effectively promote something we poorly understand because we have not examined it?

THE FIRST STEP OF THE ACTION PLAN TO PROMOTE LONG-TERM RECOVERY MUST BE TO DETERMINE WHAT WE NEED TO KNOW AND TO SEEK ANSWERS.

WHAT DO WE NEED TO KNOW?

What is recovery? Specifically what are the required ingredients: abstinence PLUS WHAT? In which domains is improvement required for there to be “recovery” not only in the eyes of society but also for the individual?

Relatedly, there is preliminary evidence that quality of life satisfaction prospectively predicts sustained *abstinence* by maintaining motivation.⁶ ***What constitutes a satisfying quality of life in recovery?*** How does that change over time?

For individuals to achieve long-term recovery, they need to initiate recovery. Many individuals with severe problems require multiple attempts before truly initiating the recovery process. What needs to “click” in the person? What is the catalyst? How can professionals (both traditional treatment providers and providers of non-traditional support services) shorten the typical addiction career?

Research shows ***differences in dependence and cessation trajectories across drug classes***,⁷ What are the implications of these findings for recovery-oriented services, specialty care, recovery outcomes, patterns and determinants?

The risk of return to active addiction becomes minimal after 5 or more years of abstinence. What else needs to happen for individuals to achieve and sustain recovery? **What is *long-term recovery***? What degree of improvement in which life domains are required for the individual to have something s/he does not want to lose to active substance use?

Multiple paths to recovery - How do people recover? What works? For whom? When? Under which circumstances (low/high recovery capital, severity, etc.)? Not only to initiate recovery but to *sustain* it over five years, ten years, or for life? Though participation in treatment and 12-step fellowship programs appears effective for some, many do not participate in either and reoccurrence rates are high even among those who do participate. Further research is needed on natural recovery, religious and spiritual recovery, secular recovery with and without the assistance of mutual aid involvement and/or professional treatment, the use of recovery homes, recovery coaches and other emerging forms of recovery management. Through the multiple pathways available, **what are the common themes in recovery?**

What are the effectiveness and cost effectiveness of recovery-oriented systems of care (ROSC) in terms of lives and dollars saved, communities restored, families reunited, employment rates increased (or absenteeism decreased) and demonstration of good “citizenship”?

What is the most effective ***role of peers in recovery services***?

How is recovery from addiction similar to and different from recovery from other chronic conditions? From medical conditions (e.g., diabetes and arthritis)? From mental health conditions (e.g., depression and PTSD)? *From recovery from other “addictions”* (e.g., internet, gambling, food, sex, and shopping)? What can we learn from other fields, and, specifically, for which aspect of addiction recovery must we devise specific interventions, paradigms, and/or measures?

There is a high rate of ***co-occurring physical and mental health chronic conditions***; to date the addictions field has focused almost exclusively on psychiatric comorbidity and on HIV. How do other comorbid chronic conditions affect the initiation and maintenance of recovery? How do we integrate the multiple systems of care that are required to support wellness for persons with multiple conditions?

How do we disseminate the message of hope and increase the attractiveness of recovery services?

WHAT WILL THE SCIENCE OF RECOVERY TELL US THAT WE DO NOT ALREADY KNOW?

Before asking what the science of recovery will tell us, we must commit to making the science of recovery a true science. The research questions and methods may differ, but the same high scientific standards must be upheld so that *the science of recovery is as good (or better) as the science of addiction*.

The ultimate goal of science is to inform clinical practice to improve lives. The science of addiction has and will continue to elucidate “the problem” (the multiple causes of substance use disorders) and to inform strategies to address it. We have a solid understanding of why and how people become substance dependent (e.g., brain studies and biology) that is being translated into therapies to lead substance dependent persons out of addiction. *The science of recovery will complement the science of*

addiction and lead to more and diverse effective strategies to promote healthy, satisfying, productive lives among formerly dependent individuals.

The science of recovery will inform the recovery community as well as service development, policy and funding and make significant contributions to our nation's health and its economy. The mere action of making wellness a bona fide outcome will help reinforce the fact that recovery from addiction can be and is a reality for many. By extension, this can give hope to the many individuals and families affected by substance use disorders and support them in their search for the solution that will work for them.

Empirically-derived knowledge about *recovery as a multi-dimensional, dynamic construct* will provide clinicians, the recovery community, and other stakeholders with realistic expectations and goals. It will inform the development of tools to measure recovery and identify recovery milestones. This will help track change over time (not only in terms of abstinence but also in terms of global functioning), inform changing service/support needs as the process unfolds, help payers and prospective clients to select and evaluate services, and facilitate research to quantify the effectiveness and cost-effectiveness of recovery-focused services. Identifying the benefits of recovery, not only to society but also to the individual, makes recovery-oriented substance abuse services more attractive than those "selling" abstinence alone. This can contribute to a greater number of individuals seeking help and thus enhance the likelihood that a greater number of persons who need help seek it and receive it. This can ultimately translate into minimizing the many costs of active addiction-quantifiable costs such as those for healthcare, crime, infectious diseases and other medical consequences of addiction, loss of productivity, and less easily quantifiable costs related to families, children, and communities.

Empirically-derived knowledge about the phenomenology of *long-term recovery* (when is recovery "stable"? "sustained"?) will contribute to minimizing many of the current societal barriers to recovery. As mentioned above, these barriers tend to manifest themselves as discriminating policies and pervasive stigma attached to persons who have a history of addiction related to quality of life issues such as employment, housing, and professional licensures.

The science of recovery will allow us to quantify the likelihood of recovery from substance use disorders regardless of path, and identify factors that promote and hinder the process. By learning how recovery is attained and sustained, information will emerge about the various "paths" to recovery (professional treatment, self help, religious and spiritual recovery, and others perhaps yet unidentified), help determine whether specific paths are indicated for certain groups of individuals and individuals themselves (depending on severity, substance, gender, comorbidity, recovery or social "capital"). That will provide helping professionals and persons experiencing substance use disorders a menu of recovery paths from which to choose in the same way physicians and their patients can review and select among strategies to address high cholesterol depending on the individuals' blood levels, medical and family history, and lifestyle.

Identifying the critical ingredients of recovery at successive stages of the process will inform recovery oriented systems of care, a service model that is likely to be more cost effective than the prevalent acute-care paradigm. Quantifying its effectiveness and cost effectiveness require "recovery criteria" that do not currently exist.

CURRENT BARRIERS TO THE SCIENCE OF RECOVERY

In structure and focus, addiction research funding thus far has mirrored the acute-care model prevalent in clinical practice. This approach is ill-suited to elucidating recovery from a chronic condition. Further, we have looked to other biomedical disciplines for scientific standards, at times compromising external validity ("real world relevance") in the process. These strategies are well-suited to address some questions and have yielded great advances -e.g., treatment effectiveness studies – but are ill-suited to study recovery.

Key obstacles to conducting (or rather securing funding for) recovery oriented research currently include:

- Primary focus on symptoms (substance use) and social (public health and safety)=insufficient attention to wellness (quality of life, global health)
- Emphasis on formal treatment services=insufficient attention to natural history of recovery using various paths
- Insufficient long-term studies=emphasis on the initiation of abstinence rather than on promotion of sustained wellness (long term recovery)
- Most recently: Fiscal austerity favoring shorter studies or large clinical trials of therapeutic interventions.

FUTURE DIRECTIONS

Substance abuse services are gradually becoming more “recovery-oriented” and making two significant paradigmatic shifts: (1) From the acute, intense episode of specialty care model to a continuum of multi-system care, and (2) from addressing primary symptoms to promoting global health.

“If addiction is to be studied as a chronic relapsing disease, increased follow-up periods will be necessary to advance our understanding for achieving and sustaining recovery. Advancing science in this arena will require comprehensive, individually based, longitudinal data sets.” (p.5) ⁸

What research funding agencies can do to promote long-term recovery:

- Include recovery as a bona fide topic and major goal area in agencies’ strategic plans –Recovery can no longer be treated as a secondary outcome..
- Earmark research funding (RFA) specifically to elucidate long-term recovery processes, patterns and their determinants that:
 - Adopts a longitudinal, naturalistic, developmental, “career” perspective (a la Vaillant, Hser, Moos/Timko)
 - Considers the multiple paths to recovery-not just treatment
 - Combines quantitative and qualitative methods to gain in-depth knowledge FROM (and about) persons in recovery
 - Makes wellness (recovery and global functioning), NOT substance use, criminal involvement and employment only, THE primary outcome
 - Adopt an ecologically valid “person in environment” approach rather than an individual-level approach only
 - Addresses research questions developed in partnership with service providers (to maximize technology transfer) and with the recovery community (to maximize relevance).

APPENDIX: Compilation of Recovery-Focused Questions

ACHIEVING CONSENSUS ON A DEFINITION OF RECOVERY

When "recovery" is "successful" (and that needs to be defined), what actually changes? What is gained (in which life domains are the changes)? Is anything of value lost on the way to recovery? What are the behavioral economics of recovery (gain vs. loss)?

What are the critical ingredients/required elements of sustained recovery?

In terms of substance use AND global health, i.e., other key functioning/life areas – mental health; physical health; social/family; employment/finances; living conditions; access to care; leisure/recreation; spirituality; and what else? This needs to be examined across subpopulations, primary substances, and by “recovery stages”, among others.

DESCRIBING THE RECOVERY PROCESS

- What is the phenomenology of recovery over time – What changes? How does it change?
- What is the relationship *among* the critical life domains - Are they independent? Are they cumulative? Is abstinence in addition to a fantastic family life, mediocre health and no job as predictive of sustained "recovery" as abstinence plus a mediocre family life and a mediocre job?
- What is the absolute and relative importance of each of the life domains/components: To the individual (importance ratings)? To predicting recovery maintenance? e.g., (a) Is abstinence critical to initiate change in the other domains or vice versa?; (b) is long term abstinence (say 3 years) in the absence of other positive changes enough to sustain recovery or are such persons at increased risks for relapse relative to someone with the same abstinence duration plus positive changes in global functioning? (i.e., is abstinence enough?)
- Do the relationships and rankings of multiple life domains change over time? For example, the first few months one may really enjoy waking up with a clear head or regaining the trust of family members. Then one wants a job, social relationships, a larger house, a sense of purpose, etc. At that stage, does absence of desired/needed change increase the risk of return to substance use?
- Conversely, what is the phenomenology of loss/deterioration in these domains? Does deterioration in key life domains (e.g., mental health or social functioning) lead to loss of abstinence or is abstinence lost first? Does that vary by gender, age, ethnic subgroup, or recovery stage? Could we use this information to develop a more attractive recovery sales package to various subgroups? How would selling wellness rather than abstinence influence service utilization and, ultimately, the nation's health?
- Is there a "point of no return" to active addiction/dependence - where the odds of return to active use are essentially zero - or is it really "once an addict always an addict"? If there is a "point of no return", what is the set of criteria (e.g., a given duration of continuous abstinence plus a given "level" of functioning in key domains) that allows us to predict and promote arriving at that point? This speaks to whether dependence/addiction is a lifelong illness (and restoring any "rights" or privileges, professional or otherwise, to persons with a dependence history).

DESCRIBING THE RECOVERY PROCESS: Chronology

- What is "long-term recovery" – specifically how long or does it vary and, if so, according to what?
- What are the stages of recovery? What are the important milestones in recovery?
- What are typical longitudinal patterns of recovery, and what are the critical points when people are vulnerable to relapse – e.g., late-stage relapse—after multiple years of abstinence?

BENEFITS and ECONOMICS of RECOVERY

- What are the psychosocial, medical, and neuro-cognitive changes (improvements) that result from sustained abstinence?

- For the community and for society at large, what are the “benefits” of promoting long-term recovery in terms of financial cost savings (specialty care, other social services, criminal justice system); public health and safety (crime and infectious disease transmission); productivity/employment; family/community health; and civic participation?
- How do we use this information to “sell” treatment and promote wellness?
- How does that compare to the current care model?

MEASURING RECOVERY

- Review existing measures (e.g. Quality of Life) and identify or develop a wellness-based comprehensive, multi-dimensional, psychometrically sound measure of recovery that incorporates all relevant life domains, is sensitive to change, and meaningful to the recovery community.

RECOVERY PATHS

- What are the various paths used *to initiate and sustain* recovery? These may include but are not limited to:
 - Natural recovery (no use of professional services or self-help)
 - Different modalities and models of professional/specialty services (alone or in combination with 12-step or other mutual aid). This includes psychosocial and pharmacotherapy.
 - 12-step (alone or in combination with specialty care)
 - Non 12-step mutual aid/self help (e.g., Secular Organization for Sobriety)
 - Culture-specific approaches (e.g., Wellbriety/White Bison)
 - Religion
 - Alternative methods (alone or in combination with any of the above). This may include acupuncture, hypnosis, yoga, and meditation.
- Are determinants (factors that promote and/or hinder) of recovery initiation and maintenance-promoting similar or different? How can this best be translated into recovery-oriented systems?
- If determinants differ by recovery “stage” (milestone), at which point in the process do recovery support service needs change to maximize sustained recovery?
- Given the desire to quit using, why and how does someone select a given path?
- What is the prevalence of different pathways out of addiction?
- Which “path” is more effective at engaging someone and achieving early recovery (initiation) given the person’s individual, clinical, or other characteristics?
- Which “path” is more attractive to and effective for going from early to intermediate or sustained recovery?
- Assuming each of the “paths” promotes abstinence, do they “automatically” produce increases in the other components (global functioning)?
- Is abstinence phenomenologically and neuro-cognitively the same regardless of path - e.g., voluntary, medication-assisted, and forced abstinence (controlled environment)?
- Given an equal duration of various “paths”, what is the prospective effectiveness of each (or combination thereof) to lead to sustain continued abstinence and global functioning?
- Is there an optimal combination *among* complementary paths, e.g., professional treatment to initiate recovery in addition to 12-step participation both during treatment and as aftercare?
- Do specific paths/combinations work best for specific groups of individuals (by severity, pre-recovery capital, gender, etc.)?
- Compare/contrast the phenomenology and longitudinal patterns of recovery across various pathways, e.g., with and without active 12-step involvement and/or a spiritual foundation.
- Can we identify a typology of recovery styles that can guide individual-level recommendations to maximize the attractiveness of recovery, e.g., not everyone wants to be a 12-stepper. This may be an issue of recovery “culture”.

SPECIFIC SERVICES/RECOVERY RESOURCES

PROFESSIONAL TREATMENT/SPECIALTY CARE

- Is specialty care necessary? For whom? Which level of care? Then what?
- How can we best identify when/how to move clients from different levels of care (residential to IOP, IOP to OP) to keep people engaged in the change process?
- Participation in treatment can enhance protective resources (e.g., family support, goal direction, monitoring, friend and peer norms and models, and rewarding activities) that sustain recovery.⁹ How can this be promoted systematically?

12-STEP

- What are the critical active ingredients of 12-step participation (meeting attendance and involvement such as working the steps or doing service) at successive stages of recovery?
- Deconstructing the 12-steps: What are the processes underlying the influence of each of these ingredients on abstinence (initiation and maintenance) and on global health and functioning?
- Is there a 12-stepper profile? What are the clinical, recovery capital, and demographics of persons who benefit from 12-step?
- Unlike professional treatment that is often “evaluated” months after services end (e.g., 6 months post discharge – outcome data), most studies on 12-step are conducted among individuals who are currently participating (performance data). What is the “effectiveness” of 12-step in sustaining abstinence and the other components of recovery *after* someone stops going (outcome)? Does 12-step “stay” with you after you stop going? Specifically what stays with you? Can we “bottle” this for persons who choose not to go to 12-step?

OTHER SELF-HELP/MUTUAL AID

- “Inventory” of non 12-step addiction recovery support groups
- What are the reasons for participation in non 12-step groups instead of 12-step groups? What are the benefits derived? Are they different than benefits derived from 12-step groups? Is there a certain type of individual attracted to these groups (to inform menu of recovery options)?
- What is the effectiveness of other self-help/mutual aid organizations?
- What are the underlying mechanisms of action for non 12-step groups? Are they different than 12-step groups? (what are the “universals” of recovery support groups? What is specific to each? For whom is each best indicated?)

PEER RECOVERY SUPPORT SERVICES (PRSS) AND RECOVERY SUPPORT SERVICES (RSS)

- What is the effectiveness of each at promoting entry into treatment (when indicated), abstinence, and global health? What is the effectiveness of each in keeping people engaged in the change process?
- Conduct clinical trials comparing PRSS and RSS vs. standard treatment.
- What is the cost effectiveness of PRSS and RSS compared to standard treatment?
- Are PRSS and RSS really different? (*does “peerness” matter?*)
- Are PRSS and RSS more or less effective when they are offered in treatment centers?
- What strategies are most successful in linking individuals leaving treatment (community-based or in jail/prison) to recovery community resources, including recovery support services?

OTHER

- What is the effectiveness and cost effectiveness of participation in recovery community institutions (e.g., recovery homes, recovery schools, recovery industries, recovery support centers, recovery ministries/churches) in enhancing long-term recovery?
- What is the potential of new technologies to support individual recovery alone or in combination with specialty care or other services? For example, telephone or web-based recovery coaches,

online support groups, recovery support text messages. What is feasible? For whom? What is the effectiveness and cost-effectiveness of these technologies?

RECOVERY-ORIENTED SYSTEM OF CARE (ROSC): SERVICE DEVELOPMENT AND FUNDING

- What needs to happen to transition from the acute-care model to a recovery-oriented system of care (ROSC) at the system level (e.g. statewide)? At the program level? Within the payment system (reimbursement structures)? At the clinical level as impacts services from clinicians and other service providers to individuals?
- What do service developers need to know to move a recovery-oriented system of care forward?
- How do we implement and "sell" a recovery-oriented system of care in the current beleaguered and deficit-focused system of care?
- What can the substance use disorder treatment field learn from the mental health field and other fields addressing chronic conditions about recovery-based care (wellness promotion)?
- How does the effectiveness and cost-effectiveness of ROSC compare to the prevalent acute-care model?
- Specifically what training do staff (program directors, counselors, others) need to transition to a recovery-oriented continuum of care without alienating them by implying that what they have been doing may not be working as well as we hoped?
- Can this training be streamlined (e.g., web-based) for enhanced efficiency?
- What is the feasibility and effectiveness of building performance-contracting into ROSC (assuming we arrive at recovery measure and criteria)?

MULTISYSTEMS/SERVICE INTEGRATION

- What is the best way to coordinate the provision of a spectrum of ancillary services (housing, legal problems) with specialty care to provide a truly person-centered system that promotes and sustains long term recovery?
- What is the best way to integrate professional services (specialty care, social services etc.) with the use of peers and volunteers?
- How can we foster the creation of multi-agency, multi-disciplinary service teams?

RECOVERY RESOURCES (other than paths) AND OBSTACLES

Resources and obstacles can be within and/or outside of the individual

Psychosocial resources are often investigated but not in an integrated fashion (e.g., cognitions, social environment and support, spirituality/faith)

Obstacles can include characteristics of the individual, his or her environment, as well as policies

Key questions:

- What are the factors that promote and hinder the initiation and maintenance of long-term recovery?
- How do they interact at various stages and for different populations (e.g., high/low severity, recovery capital etc.)?
- At any given recovery "stage" (early, intermediate, or sustained), what is the power (explanatory value) of each domain to predict recovery, and how do they interact (is there a cumulative effect?)
- Are factors promoting/hindering initiation and maintenance the same or different? If different, how do they differ, and what services and other support are needed for initiation and maintenance?
- What is the role of family in the individual recovery process?
- What are the stages (and needs) of family recovery?
- Do stigma and discrimination hinder recovery initiation? Recovery maintenance? How so? What policy changes are needed?

“SPECIAL” POPULATIONS and SOCIOCULTURAL ISSUES

Where feasible, the key questions addressed in a comprehensive recovery-focused research agenda must be considered for large subgroups to determine where differences and similarities lie. This will guide policy and services. Subgroups include but are not limited to:

- Youth, women, Native Americans, Latinos, dually-diagnosed (co-occurring), people in medically-assisted recovery, veterans, “older” (over 50!), rural populations, ex-offenders, incarcerated individuals, trauma survivors, persons who are HIV+ and/or HepC+, persons with multiple dependences or addictions (e.g., substance use and gambling or food).
- Identify cross-cultural as well as culture-specific patterns and processes of long term remission as a function of different socio-political and service delivery contexts. Stated differently: what is the role of the sociopolitical context in how recovery is conceptualized, sought, attained and experienced?

DISSEMINATING THE MESSAGE OF HOPE/PROMOTING RECOVERY: HOW DO WE SELL RECOVERY?

- How many people in the US are there in recovery (assuming we have a definition)? How many are in long-term recovery? (this would give the recovery movement a “constituency” to advocate for services, funding and policy change.)
- How do we disseminate the message that long-term recovery is attainable and there are multiple paths to achieve it?
- Are there ways to think about the *styles of recovery* (identity and relational patterns) that will encourage more individuals to seek and sustain their recovery given that current treatment is not attractive to many who need it?
- What are effective ways/venues to communicate with people needing/seeking recovery, to engage and sustain them in that pursuit? What “sells” recovery? What sells treatment? Clearly the promise of abstinence is not enough.
- What are effective ways to communicate with people about how to evaluate and use information about pathways to recovery to make informed choices?
- What role does the media portrayal of people with addiction problems and the coverage of addiction issues have in encouraging (or not) people to seek and sustain their recovery?

Reference List

1. McLellan AT. Is addiction an illness? Can it be treated? In Haack, MER, Adger Jr. H. (Eds.) *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation’s Health Professional Workforce for a New Approach to Substance Use Disorders*. Providence, RI: Association for Medical Education and Research in Substance Abuse; 2002:67-94.
2. Vaillant GE; *The Natural History of Alcoholism Revisited*. Cambridge, MA: Harvard University Press; 1995.
3. World Health Organization - European Regional Office. Copenhagen, Denmark: WHO; 1986.
4. White W. Perspectives on Systems Transformation: Recovery as an Organizing Concept. An Interview with H. Westley Clark. 2007; accessed February 7, 2008. Web Page. Available at: <http://www.glatc.org/Interview%20With%20H.%20Westley%20Clark,%20MD,%20JD,%20MPH,%20CAS,%20FASAM.pdf>.
5. Belleau C, DuPont R, Erickson C, et al. What is recovery? A working definition from the Betty Ford Institute. *J Subst Abuse Treat*. 2007;33:221-228.
6. Laudet A, Becker J, White W. Don’t wanna go through that madness no more: Quality of life satisfaction as predictor of sustained substance use remission.
7. Substance Abuse and Mental Health Services Administration OoAS. *The NSDUH Report: Substance Use and Dependence Following Initiation of Alcohol or Illicit Drug Use*. Rockville, MD: SAMHSA; 2008.

8. Hilton TF, Chandler RK, Compton WM. Needed: longitudinal research that can inform dynamic models for the treatment of addiction as a disease. *Eval Rev.* 2008;32:3-6.
9. Moos RH, Moos BS. Protective resources and long-term recovery from alcohol use disorders. *Drug Alcohol Depend.* 2007;86:46-54.