Recovery, a concept once associated almost exclusively with 12-step fellowships such as Alcoholics Anonymous, has become a buzz word in government agencies. In the US, this includes the National Institute on Alcohol Abuse and Alcoholism renaming its Division of Treatment to Division of Treatment and Recovery Research, the White House’s new Recovery Office, the Center for Substance Abuse Treatment’s Recovery Community Support Programme and state Offices of Alcoholism and Substance Abuse Services’ inclusion of Recovery Services on their websites. The UK recently saw the formation of the Recovery Academy, Recovery Group UK and UK Recovery Foundation and Scottish Drugs Recovery Consortium, while the NTA, DrugScope and UKDPC have also started using the term. Decades before these, the Addiction Recovery Foundation has been supporting professionals guiding patients into recovery – and the patients and families – when almost no one thought addicts could recover and lead fruitful lives.

As “recovery” increases in popularity, there is little consensus on what the term means – which hinders service development and evaluation, and funding/policy decisions (Maddux & Desmond 1986). Treatment services are expected to foster recovery and researchers to evaluate treatment’s effectiveness in reaching that goal. This requires that the goal be defined, and that there is consensus among the various stakeholders: policymakers, funding sources, the general public, helping professionals, and clients of services.

Most biomedical fields have a relatively clear-cut consensual definition of what ‘remission’ means: for instance, five years disease-free in oncology (Reis et al 2003). But the drug and alcohol field does not have this clarity.

This article summarises empirical data about how recovery is defined, experienced, attained and maintained and about key obstacles to this process, with emphasis on data obtained from people living the recovery experience. Implications are derived from these findings to guide service and policy development and evaluation.

**WHAT DOES “RECOVERY” MEAN?**

Most researchers define “recovery” in terms of substance use only (Cisler, Kowalchuk, Saunders, Zweben, & Trinh, 2005) and most often as abstinence – either total abstinence from alcohol and all other drugs, or from the specific substance under study (Burman 1997; Flynn Joe, Broome, Simpson & Brown, 2003; Granfield & Cloud, 2001; Scott, Fos, & Dennis, 2005). Determining what authors mean by “recovery” in scientific articles often does not become clear until the Methods section. There, “recovery” typically vanishes, to be replaced without explanation by “abstinence” (eg, Fiorentine & Hillhouse, 2001). A few authors define recovery in terms of DSM Diagnostic & Statistical Manual criteria. For instance, one group defines years of intervening recovery “as the sum of all the yearly intervals during which alcohol use disorder diagnosis was not present” (McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005, p 223; also see Dawson et al, 2005). The emphasis on abstinence is also consistent with the American Society of Addiction Medicine’s definition of recovery as “overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety”.

We conducted a study among former substance users, the Pathways Project, to examine the question. 289 participants had had a severe history of DSM-IV dependence to crack or heroin lasting on average 18.7 years, and had not used any illicit drugs for an average (mean) of 31 months when they entered the study. They were asked to select the statement best corresponding to their personal definition of recovery – 86.5% endorsed total abstinence (Laudet, 2007).

Because the treatment system in the US is strongly influenced by 12-step ideology (McElrath, 1997), we repeated the study in Melbourne, Australia, where the approach to substance user services focuses on a harm-minimisation ideology. Australian participants were also people who had experienced a long and severe history of dependence, mostly to heroin, but who had not used any drugs recently. 73.5% of Australian participants endorsed total abstinence from both drugs and alcohol as their personal definition of recovery (Laudet & Storey, 2006).

These findings are not surprising; addiction has relatively recently been conceptualised medically as a chronic condition (McLellan, Lewis, O’Brien, & Kleber, 2000) and recent studies indicate that resolving addiction often takes multiple attempt and treatment episodes often spanning two decades or longer (Dennis, Scott, Funk, & Fos, 2005; Laudet & White, 2004).

People going through several cycles of abstinence followed by relapse might conclude that total abstinence is the best strategy to prevent relapse and corresponding negative consequences.

Several studies have found that most failed remission attempts are based on moderation and that abstinence proves more successful (Burman, 1997; Maito, Clifford, Longabaugh, & Beattie, 2002).

In 2008, Ilgen and colleagues reported findings from a 16-year follow-up study of people who sought help for an alcohol disorder. One year after intake into the study, participants were classified in one of three groups according to their use of alcohol in the previous year: abstinence, non-problem drinking and problem drinking. Over the subsequent 15-year study period, non-problem drinking was less stable than abstinence (Ilgen, Wilbourne, Moos, & Moos, 2008).

So in terms of substance use, recovery from alcohol or drug abuse/dependence appears to be best defined as abstinence from all mood-altering substance.

**IS THAT ALL THAT RECOVERY MEANS?**

In the Pathways Project, we also used qualitative methods and examined verbatim answers to the question: “How would you define recovery from drug and alcohol use?”.
43% of participants defined recovery in terms of substance use, typically abstinence, especially those whose abstinence duration at intake was under three years. But over half gave answers that did not bear on substance use – see table below. One of the frequent themes regardless of people’s definition of recovery was that recovery is the process of regaining an identity (a self) lost to addiction (Laudet, 2007).

**Recovery definition:**

Key themes from qualitative data analyses

“How would you define recovery from drug and alcohol use?” (n=289)

<table>
<thead>
<tr>
<th>Substance use-related definitions</th>
<th>43.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>– no use of any drug or alcohol</td>
<td>40.3</td>
</tr>
<tr>
<td>– controlled use of drugs and/or alcohol</td>
<td>3.7</td>
</tr>
<tr>
<td>Recovery as a new life</td>
<td>22%</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>13%</td>
</tr>
<tr>
<td>A process of working on yourself</td>
<td>11.2%</td>
</tr>
<tr>
<td>Living life on life’s terms (acceptance)</td>
<td>9.6%</td>
</tr>
<tr>
<td>Self-improvement</td>
<td>9%</td>
</tr>
<tr>
<td>Learning to live drug free</td>
<td>8.3%</td>
</tr>
<tr>
<td>Recognition of the problem</td>
<td>5.4%</td>
</tr>
<tr>
<td>Getting help</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

In our study, even among participants who did not define recovery in terms of substance use, abstaining from all mood-altering substances is regarded as a prerequisite to the other benefits of recovery.

Key factors in the decision to initiate recovery, both in the US and Australia, include not liking where one’s life is going, being tired of the drug life, the desire to get better, concerns about the consequences of substance use on oneself and on others, difficulty getting along with others, and seeing the negative consequences of use on other substance users (Laudet & Sgro, 2007).

Cessing drug use after a decade or longer of ongoing use is not likely, in and of itself, to ‘result’ in reverting these losses. Thus recovery goes beyond abstinence to encompass all areas of functioning affected by active use as well as those that might have facilitated the initiation of substance use (e.g., self-esteem, peer group norms, social conditions). Most clinical interventions, especially those for chronic conditions and public health problems, are evaluated not only for their effectiveness at reducing symptoms but also for their extended effects on the disease-related costs to the individual and to society (Stewart & Ware, 1989). McLellan and colleagues made the argument that “Typically, the immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety – ie recovery” (McLellan et al, 2005).

“This is consistent with the World Health Organisation’s conceptualisation of health as “a state of complete physical, mental, and social wellbeing, not merely the absence of disease” (World Health Organisation, 1985).”

**Satisfaction with life as predictor**

Quality of life is an area that remains neglected in the substance use disorder arena relative to other biomedical fields (Donovan, Mattson, Cisler, Longabaugh, & Zweben, 2005; Finney, Moyer, & Swearingen, 2003; Morgan, Morgenstern, Blanchard, Labouvie, & Bux, 2003; Preau et al., 2006; Rudolf & Watts, 2002; Smith & Larson, 2003) – even though it plays a potentially significant part in the recovery process.

For example, among Pathways participants, higher levels of satisfaction with life predicted sustained abstinence from drug and alcohol use one and two years hence. Higher life satisfaction is thought to sustain motivation for abstinence (Laudet, Becker, & White, in press).

These findings are consistent with the Betty Ford and US government definition of recovery as “a voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship”.

**Factors linked to enhanced recovery outcomes.**

Research on quality of life among substance users is in its infancy. We examined the individual and combined contribution of duration of abstinence and of ‘recovery capital’ operationalised as social supports, spirituality, meaning, religiousness and 12-step affiliation, on QOL satisfaction in our Pathways sample. Quality of life satisfaction increases significantly as a function of duration of abstinence, while stress decreases over time (Laudet, Morgen, & White, 2006).

Overall, a number of factors have been empirically demonstrated to promote reductions in substance use and to enhance wellbeing or life satisfaction and are often cited as important by persons in recovery. These protective factors or ‘recovery capital’ (Granfield & Cloud, 2001; Laudet & White, 2008) include motivation for change (especially motivation for abstinence), coping skills to deal with stress and temptations to use without resorting to drugs or alcohol, and sources of emotional support (friends and family, peers, spirituality and faith).

Over the page, we look at enhancing recovery capital with participation in 12-step fellowships, barriers to seeking help, reasons for dropping out, and implications for treatment and policy.
RECOVERY: HELPS, HINDRANCES AND THE WAY AHEAD

Alexandre Laudet continues her empirical look at recovery, focusing on building ‘recovery capital’, tearing down barriers – and implications for treatment and policy.

Treatment services tend to be relatively short – notably four weeks in rehab – and skills acquired during treatment do not always endure after treatment as the individual might revert to pre-treatment behaviours and socialisation patterns. Participation in ‘stepped down’ continuing care after treatment is recommended and effective to solidify treatment gains (McKay et al, 1998) – but most programmes do not offer these services.

There is where 12-step fellowships such as Alcoholics and Narcotics Anonymous step in as aftercare (Tonigan, Toscova, and Miller, 1996). These organisations are particularly well-suited to provide ongoing recovery support from chronic substance abuse and dependence because, unlike limited-time formal services, they are widely and consistently available free of charge.

Participation in 12-step groups exposes members to peers – who share common problems they seek to address – succeeding at remaining drug free, so providing role models with whom they can identify, evidence that recovery is attainable, strategies to cope with temptations to use and with other stressors, emotional support to deal with the challenges of recovery, a spiritual foundation for those who choose (Alcoholics Anonymous World Services, 1939-2001), and opportunities to socialise with non-drug-using peers (Humphreys & Noke, 1997; Humphreys, Mankowski, Mou & Finney, 1999; Laudet, Clidand, Magura, Vogel & Knight, 2004; Morgenstern & McCrady, 1993; Morgenstern et al, 2003; for review, see Humphreys, 2004).

Among people concurrently in professional treatment, 12-step meeting attendance produces independent and additive effects to treatment outcomes (Fiorentine & Hillhouse, 2000).

This support is especially important after treatment ends: it is a strong predictor of abstinence even in long-term studies (Kaskutas et al, 2005; Kelly, Stout, Zyzik & Schneieder, 2006; Laudet et al, 2007; Morgenstern et al, 2003). The effectiveness of 12-step participation rises in tandem with addiction severity (Tonigan et al, 1996). And one study reported a stronger link between 12-step attendance and abstinence among patients who were younger, white, less-educated, unstably employed, less religious and less interpersonally skilled, individuals who might have fewer social resources and so benefited more from the fellowship and support for abstinence (Timko, Billow, & DeBenedetti, 2006).

12 STEPS BUILD RECOVERY CAPITAL.

The benefits of 12-step participation extend beyond substance use (Humphreys et al, 2004). Research has documented the benefits in:

- psychosocial functioning and recovery-promoting domains, including enhanced self-efficacy to resist temptations to use drugs and/or alcohol and motivation for abstinence (Kelly, Myers, & Brown, 2000; Morgenstern, Labouvie, McCrady, Kahler & Frey, 1997)
- improved coping strategies (Humphreys, Finney et al, 1994; Humphreys, Moos & Finney, 1996; Morgenstern et al, 1997; Timko, Finney, Moos, & Moos, 1995; Timko, Moos, Finney, & Lesar, 2000; Snow, Prochaska, & Rossi, 1994)
- improved social support and particularly social support for recovery (Humphreys & Noke, 1997; Humphreys et al, 1999)
- reduced psychological problems such as depression and anxiety (Gossop et al, 2003)
- lower stress (Lauder & White, 2008)
- higher quality of life (Gossop et al, 2003) and
- higher levels of life meaning and purpose (White & Laudet, 2006).

Overall, participation in 12-step appears to constitute an effective and cost-effective recovery resource, both during and after formal services.

IDENTIFY AND REMOVE BARRIERS.

Examining reasons for non-participation in or attrition from treatment and/or 12-step can help elucidate barriers to recovery. There are systemic and structural barriers (Blankenship, Friedman, Dworkin, & Manteil, 2006) to help-seeking that include wait-lists and decreased treatment quality (McLellan, Chalk, & Bartlett, 2007).

In one study among clients in publicly funded outpatient substance user treatment in New York City, 59.8% dropped out (Laudet et al, 2007). We examined participants’ answers to open-ended questions about why they left treatment (n=194).

Reasons for dropping out

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not want help/not ready to stop</td>
<td>31%</td>
</tr>
<tr>
<td>Treatment interferes with responsibilities</td>
<td>23%</td>
</tr>
<tr>
<td>Personal problems interfere with attendance</td>
<td>17%</td>
</tr>
<tr>
<td>Logistic reasons – eg, location, moving</td>
<td>15%</td>
</tr>
<tr>
<td>Services were not helping</td>
<td>9%</td>
</tr>
<tr>
<td>Administratively discharged</td>
<td>6%</td>
</tr>
</tbody>
</table>

POLICIES TO FOSTER RECOVERY.

To foster recovery as defined here, the system of care and evaluation must make two major shifts.

First is a shift away from symptom-focused care and evaluation to wellness-oriented practices as adopted by other biomedical disciplines where quality of life is increasingly recognised as a bona fide treatment goal and outcome of evaluation research (Foster, Powell, Marshall & Peters, 1999).

Second is a move away from the prevalent acute model toward a model of continuing care – from early case finding through planned aftercare and needed follow-up – and sustained recovery management. Such a model emphasises post-treatment monitoring and support, active linkage to recovery mutual-aid resources, stage-appropriate recovery education and, when needed, early re-intervention (White, Boyle, & Loveland, 2002). There is empirical support for this (Scott, Dennis, & Foss, 2005).

Interventions in less specialised settings must also be implemented, to promote help-seeking.