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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, Moos & Finney, 1999; Laudet, Cleland, 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, Zywiak & Schneider, 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 J & Moos RH 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 (*Laudet & 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, & Mantell, 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

Disliked an aspect of the agency
– programme, staff, clients 31%
Did not want help/not ready to stop 23%
Treatment interferes with responsibilities
– work, school 17%
Personal problems interfere with attendance 15%
Logistic reasons – eg, location, moving 15%
Services were not helping 9%
Administratively discharged 6%

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.

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