

Recovery from drug and alcohol dependence: an overview of the evidence

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ACMD

Advisory Council on the Misuse of Drugs

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20th December 2012

Dear Minister,

I am writing to you in your role as Chair of the Inter Ministerial Group on Drugs (IMG), with the Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee's first report.

The ACMD Recovery Committee was formed in response to an invitation from the IMG. It has been created as a standing committee of the ACMD with membership drawn from the Council plus co-opted external expertise.

The Recovery Committee's first report is the result of an exercise to scope the evidence, or lack thereof, for the many and complex factors that may contribute to recovery from drug or alcohol dependence. You will see the report highlights that recovery from dependence on drugs and alcohol is a complex, and rarely linear process. The journey to overcome dependence, re-integrate into society and achieve a degree of well-being and social integration is highly individual to the person.

The purpose of the report is to 'map the terrain' of recovery, which will then be examined in more detail in our future reports. Indeed, the Recovery Committee has begun work on its next report, which will attempt to answer the question: "What does evidence tell us (and isn't available to tell us) about the recovery outcomes we can expect from drug and alcohol dependence".

We welcome an opportunity to discuss this report with you and your IMG colleagues in due course.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Les Iversen'.

Professor Les Iversen
Chair, ACMD

cc:

Rt. Hon. Theresa May MP – Home Secretary
Anna Soubry (DoH)
Oliver Letwin MP (Cabinet Office)
Jeremy Wright (MoJ)
Don Foster (DCLG)
Esther McVey MP (DWP)
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Sajid Javid MP (Treasury)
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Glossary

Recovery capital

Recovery capital refers to the ‘breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery’ from substance misuse (dependency) (Granfield and Cloud, 2001). In 2009, Granfield and Cloud revisited their initial concept and argued that there are four components to recovery capital:

- **Social capital** is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.
- **Physical capital** is defined in terms of tangible assets such as property and money that may increase recovery options (e.g. being able to move away from existing friends/networks or to fund an expensive detox service).
- **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem-solving that is required on a recovery journey.
- **Cultural capital** includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

1. Introduction and scope of this report

- 1.1. The Recovery Committee of the ACMD was formed in response to an invitation from the Inter Ministerial Group on Drugs (IMG). It has been created as a standing committee of the ACMD with membership drawn from the Council plus co-opted external expertise.
- 1.2. The Recovery Committee supports the ACMD in its duty to provide evidence-based advice to Government on recovery from dependence on drugs and alcohol and (later in its work) how best to prevent drug and alcohol misuse and the harms it causes. It is doing this by examining the wide range of potential themes that could contribute to recovery, reviewing the evidence for their contribution, identifying priority areas for action, and producing guidance for those involved in the strategy, commissioning and delivery of interventions responding to drug and alcohol misuse.
- 1.3. The remit of the Recovery Committee concerns recovery from dependence on drugs and alcohol, not *use* of drugs or alcohol per se.
- 1.4. This first output of the ACMD Recovery Committee provides an overview of the evidence, or lack thereof of the factors that contribute to recovery.
- 1.5. This document is not intended to offer definitive answers and did not involve an *in depth* analysis of evidence. Rather it is intended to 'map out the terrain' that will be examined in more detail later in the work of the committee.
- 1.6. The ACMD identified 13 different themes that had a bearing on recovery: carers and families; communications including stigma and media; criminal justice; education (including adult education, higher education, schools) and training; employment and volunteering; housing; natural recovery; personal finance (including benefits); health and wellbeing; recovery communities; social care; local communities; and substance misuse treatment.
- 1.7. Consistent phraseology has been used throughout to indicate the strength of the evidence found:

- Strong research evidence – evidence from Cochrane review or high quality randomised controlled trials (RCTs)
- Research evidence – evidence from controlled studies or quasi- experimental studies
- Emerging research evidence – evidence from descriptive or comparative studies, correlation studies, surveys or evaluations
- Expert panel evidence – evidence from expert panels
- Expert by experience evidence – evidence from those with lived experience
- Lack of evidence – no evidence for or against either way
- Conflicting evidence – situations where some evidence supports a hypothesis and other evidence does not

- 1.8. After exploring each theme, the issues are re-examined through a slightly different lens, as different forms of recovery capital: social, physical, human and cultural capital. A summary of initial findings is presented under these headers.

- 1.9. In the scoping document the particular needs of different groups of drug and alcohol users are briefly considered, including young people, older people, women, black and minority ethnic communities and lesbian, gay, bisexual and transgender (LGBT) communities. As more work is done on particular themes, in subsequent reports, diversity impact considerations will be addressed in more detail.

2. Informing future work

2.1. The Recovery Committee will use the results of this scoping work to help identify key priorities for future work. In particular, questions will be identified:

- that if answered, may have a material impact on practice and improve rates of recovery;
- that are currently un-answered, or where there are ‘competing narratives’ that may not have been subjected to a thorough review of evidence; and
- for which there is a realistic prospect of collating sufficient evidence to reach conclusions which may have an impact on policy or practice.

2.2. Future work carried out by the Recovery Committee will focus on specific questions that meet these criteria. Each of these more detailed reviews will result in a short and focussed report. Each review will be based upon a standardised procedure designed to collate a wide range of evidence (Shekelle *et al.*, 1999, which was operationalised by the British Association for Psychopharmacology to produce its guidelines (Lingford-Hughes *et al.*, 2012). This process aims to allow for transparency around how the Recovery Committee hears its evidence and draws its conclusions.

3. What is dependence and recovery?

- 3.1. The ACMD recognizes that there are a number of definitions of dependence and recovery. The following definitions set the context for the scoping work that has been undertaken.

Dependence

- 3.2. The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defines dependence as:

a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance takes on a much higher priority for a given individual than other behaviours that once had greater value. The desire to take the psychoactive drugs, alcohol, or tobacco is strong or overpowering and relapse after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

- 3.3. A diagnosis of dependence would be made if three or more of the following criteria have been present together at some time during the previous year:

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- A physiological withdrawal state when substance use has ceased or has been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses.
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as liver damage through excessive drinking, drug-related impairment of cognitive functioning, and damage to relationships.

- 3.4. Research evidence and clinical practice on substance use, dependence and treatment indicates that not everyone who uses substances becomes dependent. For those that do become dependent, there may be different degrees or severities of dependency either related to the individual, the substance or their environment, circumstances or a combination of factors.

What is recovery?

- 3.5. There are multiple definitions of recovery, some of which are presented below. Most of these recognise that recovery is a process, not a single event or end point.

- 3.6. The 2010 UK Drug Strategy notes that recovery:

involves three overarching principles– wellbeing, citizenship, and freedom from dependence...It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people.

- 3.7. The Scottish Government (2008) defines recovery as:

a process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society... recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment...an aspirational and person-centred process.

- 3.8. The UK Drug Policy Commission (UKDPC) recovery consensus group (2008) defined recovery as:

voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.

The consensus group suggests that there are various routes to recovery, including 'medically-maintained abstinence'.

- 3.9. In the USA, The Betty Ford Institute Consensus Panel (2007) defined recovery as:

'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship.' The Consensus Panel further detailed the meaning of sobriety by explicitly stating that: *'formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other non-prescribed drugs would meet this definition of sobriety'.*

- 3.10. Also in the USA, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined "recovery from mental disorders and substance use disorders" as:

'A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential'.

- 3.11. SAMHSA noted four major dimensions that support a life in recovery: health, home, purpose and community.

- 3.12. William White notes that recovery from a substance use disorder has been characterised by three core dimensions of change: remission of the substance use disorder; enhancement in global health (physical, emotional, relational, occupational and spiritual); and positive community inclusion (White, 2007).

- 3.13. The UKDPC discusses recovery as accruing positive benefits, not just reducing or removing harms caused by substance use. Recovery is about building a satisfying and meaningful life, as defined by the person themselves, and involves participation in the rights, roles and responsibilities of society. Recovery may be associated with a number of different types of support and interventions or may occur without any formal external help: no 'one size fits all'. Recovery also embraces inclusion, or a re-entry into society and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to include being able to participate fully in family life and be able to undertake work in a paid or voluntary capacity (UKDPC, 2008).

- 3.14. The ACMD Recovery Committee notes that recovery is an ambitious concept that may require someone with drug or alcohol dependence to both overcome that dependence and also achieve a way of life, improvements to well-being and social integration that they did not have prior to developing substance misuse problems.

4. Scoping the evidence: the contribution of different themes to recovery

- 4.1. The following selected themes provide one way of examining the evidence across the different factors that may influence recovery outcomes.

Carers and families

- 4.2. There is emerging evidence that support for the carers of substance users has an impact upon the substance user, including getting reluctant users into treatment, reducing their use and making better progress through treatment.
- 4.3. There is strong research evidence that Behavioural Couples Therapy (BCT) is effective in improving social support and reducing substance misuse amongst those with dependence (NICE, 2007).
- 4.4. There is research evidence that for some people, historic and current family dysfunction is an impediment to recovery.
- 4.5. There is research evidence that for some people the family may enable recovery and be 'part of the solution'. For example, there is research evidence that non-using family members who engage in BCT and support the person with dependence can have a positive impact on the recovery outcomes for their dependent relative.

Communications including stigma and media

- 4.6. There is emerging research evidence that stigma negatively affects access to treatment and chances at recovery and reintegration (UKDPC 2008).
- 4.7. There is emerging research evidence that work with potential employers, including use of non-stigmatising language and modifying attitudes towards drug users, may increase opportunities for those in recovery (UKDPC 2008).
- 4.8. There is emerging research evidence that communicating positive stories about people in recovery reduces stigma for this group (Livingston *et al.*, 2012).
- 4.9. There is emerging evidence that contact-based training and education programs targeting medical students and professionals are effective at reducing stigma amongst these groups (Livingston *et al.*, 2012).
- 4.10. There is emerging research evidence that self-stigma can be reduced through therapeutic interventions and mutual aid (Livingston *et al.*, 2012).

Criminal justice

- 4.11. There is emerging research evidence that the provision of substance misuse treatment in prisons can save lives, particularly for people who are alcohol-dependent.
- 4.12. There is research evidence that criminal justice interventions reduce re-offending, predominantly in men under the age of 35 (Wexler *et al.*, 1999).
- 4.13. There is research evidence that coercion can be an effective way of getting people into treatment, for example the Drug Interventions Programme (Skodbo *et al.*, 2007).
- 4.14. There is research evidence from the US that Drug Courts can be effective at reducing drug use (Wilson *et al.*, 2006).
- 4.15. There is expert by experience evidence that mutual aid in prisons has a positive impact, but that access to it is poor.

Education (including adult education, higher education, schools) and training

- 4.16. There is emerging research evidence from the USA that integrating education and training services within substance misuse treatment programmes can be a cost effective way of improving employment outcomes.
- 4.17. There is a lack of evidence about the 'Recovery School' model from the USA (White *et al.*, 2006).
- 4.18. Overall, there is a lack of evidence to properly evaluate the use of education and training approaches in supporting recovery outcomes (Magura *et al.*, 2004).

Employment and volunteering

- 4.19. There is emerging research evidence that for some substance misusers, becoming a volunteer can help recovery. There is expert panel evidence and expert by experience evidence that excessive pressure or stress around volunteering can impede recovery.
- 4.20. There is research evidence that gaining employment that is conditional on sobriety can increase recovery, for example in a study of a Native American community in the USA.

Health and wellbeing

- 4.21. There is research evidence that substance misusers experience increased morbidity. This includes higher rates of blood-borne viruses and infections, particularly among drug injectors (NICE, 2009); increased rates of liver disease among those who are alcohol-dependent; and increased rates of lung disease among drug smokers (ACMD, 2011). There is research evidence that a range of substance misuse treatment services can be effective in reducing these health problems by helping reduce or stop substance use and injecting, reducing HIV prevalence (Gowing *et al.*, 2011; World Health Organisation, 2005), reducing risk of overdose and premature deaths among heroin users (Clausen *et al.*, 2008), and facilitating access to physical and mental healthcare (NICE, 2009).
- 4.22. There is research evidence that substance misusers experience other problems of psychological health and wellbeing, such as disordered sleep, lack of exercise, mental health problems and chaotic lifestyles. There is emerging evidence that substance misuse treatment, treatment for mental health issues, mutual aid and public health initiatives can reduce these problems (NICE, 2007). There is emerging evidence that improving wellbeing will improve rates of recovery.

Housing

- 4.23. There is emerging evidence that stable housing is beneficial to recovery (CIH, 2012; Milby *et al.*, 2010; Rutter, 1999). There is emerging evidence that housing 'floating support services' are effective at helping some substance misusers sustain housing (CIH, 2012).
- 4.24. There is a lack of evidence on the impact of housing on recovery outcomes, and more work is required on the contribution of housing to recovery

Local communities

- 4.25. There is expert by experience evidence that families with access to community assets, such as involvement with community groups and churches, are less likely to develop problems with substance dependence.
- 4.26. The role of communities in recovery may be important, although this needs further exploration to determine the specific contribution. Most of the evidence that is available is from US case studies, for example from Philadelphia (Achara-Abrahams *et al.*, 2011; White, 2007b), and from New York.

Natural recovery

- 4.27. There is research evidence that many people recover from drug and alcohol dependence without formal intervention. This is most sharply illustrated by tobacco and alcohol research, though there are also important studies into this phenomenon with heroin users (Robins *et al.*, 1974), and through population studies of lifetime rates of dependence (White, 2012).
- 4.28. There is research evidence that natural recovery is far more likely for individuals with low dependency and high recovery capital. There is emerging evidence that those with high dependence and low recovery capital have a better prognosis if they engage with substance misuse treatment.
- 4.29. There is research evidence that for some people natural recovery occurs almost spontaneously, triggered by changes in life circumstances, responsibilities or outlook.
- 4.30. There is research evidence that for others, natural recovery is a more gradual process, consistent with the idea that some people simply 'mature' out of addiction.

Personal finance (including benefits)

- 4.31. There is research evidence that many of those who are trying to recover from drug dependence have financial problems, such as debts, poor employment potential, and difficulties in managing money.
- 4.32. There is research evidence that the use of heroin, crack and cocaine increases the likelihood of an individual committing acquisitive crime.
- 4.33. There is expert by experience and emerging research evidence from surveys that debts are experienced as an obstacle to recovery.

Recovery communities

- 4.34. There is emerging evidence in the UK that a growing number of people with drug and alcohol dependence are engaged in formal recovery communities, such as 12-step fellowships and SMART Recovery.
- 4.35. There is research evidence from the USA that attending 12-step fellowship meetings improves sustained abstinence from drug and alcohol dependence.
- 4.36. There is research evidence that substance misuse treatment can improve sustained recovery outcomes (including abstinence) by actively encouraging service users to engage with mutual aid (White, 2009). There is emerging evidence that coerced engagement with mutual aid is counter-productive (Kownacki *et al.*, 1999).
- 4.37. There is emerging evidence that the primary mechanism of change afforded by these groups is the 'community of recovery' itself, and the act of collaborating in the task of supporting one another in recovery. There is insufficient research into informal peer support and other forms of recovery communities, though these may also offer similar benefits.

- 4.38. The evidence base for mutual aid is largely from the USA and focussed on 12-step approaches. There is a need to build a UK evidence base and consider issues that are key to the UK, such as: the impact of informal peer support networks; replicability of 12-step facilitation in the UK context of a largely non-12 step treatment system; and the effectiveness or otherwise of non-12-step mutual aid.

Social care

- 4.39. There is research evidence that the children of drug and alcohol dependent parents experience elevated risk of emotional and physical neglect, developing serious emotional and social problems later in life, and developing substance misuse problems themselves. This may add to potential intergenerational problems connected to drug and alcohol misuse.
- 4.40. There is emerging evidence that parental engagement with treatment is a protective factor for children and can bring about positive outcomes for both the child and parent.
- 4.41. More work is required to understand the contribution and role of social care services to recovery.

Substance misuse treatment

- 4.42. There is strong research evidence that good quality, recovery-focussed drug and alcohol treatment can help many people achieve initial recovery outcomes, including reductions in substance use and abstinence (Anglin MD *et al.*, 1997; Gossop M *et al.*, (1998).
- 4.43. There is research evidence that drug and alcohol treatment protects individuals and their communities from blood-borne viruses, overdose deaths, and substance-related crime.
- 4.44. There is research evidence that medication-assisted treatment for heroin users reduces crime, overdose death and disease (and so increases longevity compared to those not in treatment). However, it may also increase the overall length of a recovery journey.
- 4.45. There is research evidence that relapse and numerous attempts in treatment are normal features of the recovery journey for most people. There is research evidence that for those with severe dependency, the recovery journey will usually last many years.
- 4.46. There is strong research evidence that enforced detoxification is counter-productive. There is also strong research evidence that repeated detoxification from alcohol is damaging to the brain.

5. Exploring the evidence: recovery capital

- 5.1. The above exploration of the 13 themes provides one way of examining the factors which impact on recovery. This section provides an alternative lens or perspective on the same questions, based on the idea of social and recovery capital. There is some duplication, but for the purposes of this report it is useful to include both approaches.

Recovery capital – Social capital

- 5.2. There is research evidence that people from troubled, dysfunctional or substance misusing families are more likely to develop substance dependency. Where drug or alcohol dependence has occurred in this context, a family may hinder an individual's recovery unless the family are helped to resolve their own problems.
- 5.3. There is emerging evidence that supportive family members who do not have substance misuse problems themselves can be beneficial to an individual's recovery, particularly if they receive psychological interventions to enable this support.
- 5.4. There is research evidence that becoming a mother enhances recovery potential in substance dependent women, though there may still remain a range of risks to the child during early recovery.
- 5.5. There is research evidence that sustained recovery outcomes are more likely to be achieved if people engage in mutual aid (from USA evidence for 12-step fellowships). There is emerging evidence that facilitated engagement of service users with mutual aid improves recovery outcomes.
- 5.6. Emerging research evidence from the USA suggests that communities can have both important positive and negative impacts on recovery outcomes, depending on whether those in recovery are stigmatised, or local communities support recovery initiatives.
- 5.7. Emerging research evidence indicates that social capital may play a key role in recovery, particularly through the building of non-substance using family and social support networks. There is a need to build a UK evidence base on mutual aid given the USA bias in the research, and cultural differences.

Recovery capital – Physical and economic capital

- 5.8. The relationship between physical and economic capital and recovery is complex. Having physical and economic capital does not necessarily protect someone from using drugs (for example cannabis) or developing dependence, especially on alcohol.
- 5.9. There is research evidence of a greater prevalence of: poor housing; debt; unemployment, criminal activity; and poor education or vocational skills among those with heroin or crack dependence in treatment services. There is a lack of evidence and conflicting evidence whether this applies to other types of drug and alcohol dependence, where the picture seems much more mixed.
- 5.10. There is emerging evidence that having a job and interventions such as: help with personal finances; debt counselling; rent deposit schemes; and 'recovery-orientated' housing; improve a range of intermediate recovery outcomes. This appears also to be the case for offenders.
- 5.11. There is emerging research evidence from other countries that treatment rarely impacts employment status, and that those who are unemployed stay unemployed, and vice versa. There is emerging research evidence that the UK drug treatment

population has a higher rate of unemployment than the treatment population anywhere else in Europe.

- 5.12. There is a lack of evidence on the impact of interventions to reduce benefit dependence and improve employability for those with drug dependence. Emerging evidence reviews indicate such initiatives should be coupled with interventions to tackle stigma among potential employers.
- 5.13. There is research evidence that those with severe dependence often have poor physical and economic capital. Overall, there is a lack of evidence on the impact of physical and economic capital on recovery. Research is required on the efficacy of interventions to improve these recovery outcomes.

Recovery capital – Human capital

- 5.14. There is emerging research evidence that some people have an elevated risk of substance dependence due to genetic predisposition, though this does not currently appear to be a primary or dominant risk factor. Research in this area is new and more is needed.
- 5.15. There is research evidence that those with mental health problems have reduced recovery potential. There is emerging evidence that there are high levels of mental health problems in UK substance misuse treatment populations. There is also research evidence that some substance misuse causes mental health problems. There is emerging research evidence that the treatment of co-morbid mental health problems will increase recovery potential.
- 5.16. There is research evidence that substance dependency often incurs significant physical health damage which is related to the substances misused and patterns of use. For example: alcohol dependence often incurs high rates of liver damage and cognitive impairment; drug injectors have higher rates of HIV, hepatitis C and death (due to overdose); cannabis smoking carries a greater risk of smoking-related disease than cigarettes.
- 5.17. There is research evidence that substance dependence is frequently accompanied by poor diet and cigarette smoking.
- 5.18. There is strong research evidence that those with dependence generally have a shorter life expectancy than the general population.
- 5.19. The evidence therefore suggests that achieving health and well-being recovery outcomes may be one of the biggest challenges in a population with such poor physical and mental health; particularly the aging population of heroin or ex-heroin users in the UK.

Recovery capital – Cultural capital

- 5.20. There is a lack of UK evidence on the role of social conformity and the values, beliefs and attitudes of individuals and communities (cultural capital) on substance use, dependence and recovery. This is another complex area.
- 5.21. There is emerging evidence that communities with low social acceptability of substance use and dependence have lower rates of use and dependence – but where dependence occurs, individuals can be highly stigmatized.
- 5.22. There is emerging evidence that stigmatization of substance misuse can adversely impact on recovery outcomes such as employment prospects and integration into local communities.

- 5.23. There is emerging evidence that many of those in recovery go through an 'identity shift' to achieve sustained recovery.
- 5.24. There is emerging USA evidence that having 'visible recovery' initiatives, such as sobriety cafes, and high profile people in recovery, can improve community perceptions of recovery. However, there is also emerging evidence that abstinent 'recovery champions' may have a higher risk of relapse than others in recovery.
- 5.25. The role of culture and cultural capital on drug and alcohol use and recovery from dependence is complex. The values, beliefs and attitudes of individuals, communities, the media and government may impact on recovery negatively, such as stigmatising those in recovery; or positively, such as local support for recovery systems. This area requires further research including how individuals can be best supported through addiction cycles of abstinence and relapse, while minimising stigma against them.

6. Discussion

- 6.1. The initial scoping exercise undertaken by the Recovery Committee of the ACMD indicates that recovery from dependence on drugs and alcohol is a complex, and rarely linear process. The journey to overcome dependence, re-integrate into society and achieve a degree of well-being and social integration is highly individual to the person.
- 6.2. Our initial work indicates that an individual's 'recovery potential' and the speed or momentum they can achieve in recovery is influenced by a number of factors including: the substance itself; severity of dependence; an individual's 'recovery capital'; help available from treatment services, engagement with mutual aid; and the external environment and community the individual has before and during the recovery process.
- 6.3. Our review suggests that initial recovery can be enabled and supported by good quality treatment and engagement with mutual aid. However, there is less evidence concerning the other factors which influence sustained recovery.
- 6.4. Some promising areas are emerging from research and innovation. Social capital (especially a person in recovery building positive relationships with non-substance using friends, family and communities) appears to be an enabler of recovery. It is therefore likely that interventions which focus on helping people build social capital in this way, will improve rates of recovery.
- 6.5. Poor physical and mental health amongst many of those in the UK with drug or alcohol dependence may significantly disable recovery potential. Interventions to improve physical and mental health will improve recovery outcomes, though success may be more limited where those individuals have incurred 'serious collateral health damage', such as difficult-to-treat physical or mental health problems. For some people there are profound, negative and irreversible changes to health such as shortened life expectancy and cognitive functioning.
- 6.6. Similarly, in the UK many of those in recovery from severe dependence – especially on heroin and crack cocaine – have a criminal record, have lost family and relationships, or have poor education and employment histories. For these people, recovery may be a long journey, and they may require help to increase their physical and economic capital (such as housing and employment). There is some evidence that addressing stigma amongst local communities and employers may reduce barriers to these people achieving their recovery potential.
- 6.7. The scoping work has not revealed any evidence that fundamentally undermines the core aspiration of the UK drug strategy, to maximise recovery for all those with substance misuse dependence. There is evidence that many existing treatment and support strategies are already making a positive contribution to promote recovery, and that rates of recovery are improving. The evidence offers reasonable grounds for optimism that rates of recovery can be further improved, whilst also recognising that this might not be achievable for everyone.

7. Next steps

- 7.1. The conclusions in this paper are a work in progress. The Recovery Committee will continue to gather evidence, to strengthen and update the scoping paper as work progresses.
- 7.2. In subsequent papers, the Recovery Committee will look in more detail at specific questions, aiming to provide practical and evidence based advice on how to improve recovery outcomes in individuals and local systems.
- 7.3. The Recovery Committee has begun work on the first thematic report and has held evidence-gathering sessions. This report will attempt to answer the question: “What does evidence tell us (and isn’t available to tell us) about the recovery outcomes we can expect from drug and alcohol dependence”.

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