



Recovery Academy

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2010 Conference Alexandre Laudet address

Why we need to make recovery the guiding vision of substance abuse services

As a field, we have increasing evidence that addiction is indeed, for many, a chronic condition. People with severe dependence to drugs and/or alcohol often use for one or two decades, starting in adolescence, and go through multiple cycles of active addiction and treatment/abstinence before reaching abstinence if they ever do. Too many die before ever having a chance to reach abstinence and a healthy life.

The cardinal feature of a chronic condition is that there is no cure for it; however symptoms can be arrested and the disease can be in remission through the use of symptom management techniques that may include professional help such as medications or counseling. Another important feature of chronic conditions is that they are ongoing which distinguishes them from acute conditions such as a broken bone that is treated and heals. How many people do you know who have graduated from diabetes, hypertension or asthma treatment???

So as a field we have been addressing addiction as an acute condition: we assess, treat and discharge people after a short, intense episode of treatment and society expects them to be 'cured'. If they relapse, too often, this is interpreted as a sign of weak will or lack of motivation.

There is overwhelming evidence that addiction treatment 'works' but the effects are time limited: more than half people relapse, often within 90 days of leaving treatment, and that's the ones who do attain abstinence during treatment – not all do. In the US the average number of visits to an outpatient treatment (the most used modality) is ONE. People come to treatment once and they do not come back. Overall, in the US 36% of people enrolled in outpatient complete treatment. In one of our studies conducted in New York City, a third of outpatient clients sought treatment again within a year of leaving the index episode and at the end of that year, they were still showing more signs of impairment (drug use days, severity) than those who did not seek additional help...

When we ask people who left treatment why they left, they say that they didn't like something about the program, that attending the program interfered with other important things they need to do – find a place to stay, try to regain custody of their kids, go to school or find a job, that they were not ready to stop using and/or that treatment was not helpful. Asked whether there was anything the program could have done differently so that they would have remained engaged in services, a third of those who dropped out in one of our studies said yes. What did they want from the program? They wanted help with practical considerations- car fare, a food pantry; they wanted help with areas other than addiction- help finding a place to stay, getting training or employment, help with legal issues...No one said: they are not taking a urine sample often enough, people want help rebuilding their lives.

Recovery is becoming the guiding principle for treatment in the US and in the UK. **Recovery from alcohol and drug problems** is defined as **a process of change through which an individual achieves abstinence, improved health, wellness, and quality of life** (CSAT, 2005 National Recovery Summit). Recovery oriented systems of care (ROSC) is the emerging service model that seeks to promote this broader goal of recovery by offering person-centered, strength based individualized services in an integrated, multi-system model that includes peer support and wraps around the person as it were, to arm him/her with the services and supports necessary to meet changing needs as recovery unfolds.

ROSC represents two significant paradigmatic shifts relative to the current service model:

1. A shift from the acute model to a continuum of care or 'chronic care model; and
2. A shift from a pathology-focused model to one that aims to promote wellness and recovery.

Though ROSC is expected to be outcome driven and research based, we currently lack a solid science of recovery; research in the addictions has mirrored the treatment model: substance use is the primary outcome, we use short-term follow-up periods and we tend to recruit participants in treatment programs. As a result, we know little about the process of recovery beyond recovery initiation, we know little about dimensions of recovery other than abstinence, and we know virtually nothing about people who recover without treatment, though it is believed to be the most prevalent recovery path.

Building the science of recovery is an integral part of promoting recovery outcomes to inform service development, policy and funding decisions. The emerging science of recovery we currently have does tell us a few things that strongly support the ROSC model:

- People seek recovery because they don't like their life in active addiction – quality of life satisfaction is very low in active addiction
- Quality of life satisfaction increases significantly and progressively as abstinence duration increases, and stress level decreases as a function of longer abstinence time (remember that stress is a key factor in relapse to active use).
- People experience recovery as 'a new life, a second chance, a better life'. They experience recovery as a process not an end point
- Two of the critical factors people cite as helping them sustain recovery and

overcome temptations to use are seeking support (accepting help) and staying focused on recovery: making recovery a priority. Stated differently, motivation and support are key.

- The support from peers is particularly helpful because it provides role models and coping strategies, it provides hope that recovery is attainable, it provides an accepting, substance free network, and it is available for free on an ongoing basis (unlike professional treatment that has waiting lists and a finite planned duration of services)

- The 12-step fellowships such as Alcoholics and Narcotics Anonymous are the most prevalent form of peer support for addiction recovery in the US and there is a large body of science attesting to their effectiveness. As with anything else, 12-step does not work for everyone; the key is to find sources of support, especially peer support, that meet the individual's needs, acknowledging that recovery is an individual journey and everyone has different needs.

- Abstinence alone does not sustain itself: in the absence of improvement in key areas of life, just not using will not last

- Quality of life satisfaction is really what sustain abstinence; when people stop using, after a little while they report having a clearer head, better relationships with their friends and family, they have goals, their housing situation improves, they start feeling better physically and mentally. These gradual improvements represent something valued that the individual does not want to lose. This was stated quite explicitly by one of our research participants who, when asked what gave him the strength to resist the temptation to use in early recovery, said:

“What worked for me is just the thought that I don’t wanna go through that madness no more. ... See, ‘cause if I was to use again, I probably would lose everything”.

Our research shows that controlling for how long someone has been abstinent, how satisfied they are with their life prospectively predicts whether or not they will return to substance use one and two years later. This is because quality of life satisfaction sustains commitment to abstinence (motivation). The more you have to lose to addiction, the less likely you are to pick up that drink or that drug because you know that doing so may result in losing your house/job/partner/health/freedom etc...

- So our task as clinicians, researchers, policy makers, funders and concerned individuals. is to help people who have substance use problems get the resources and strategies they need to improve their lives because that is really what constitutes and also what promotes recovery.

- Let's do it!

See my web page for presentations and papers and/or contact me at:

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